BUILDING COMMUNITY SUPPORT FOR PEOPLE:

A PLAN FOR MENTAL HEALTH IN ONTARIO

The Provincial Community Mental Health Committee
Robert Graham, Chairman
July 28, 1988

Bishops Mills
Ontario

July 28, 1988

The Honourable Elinor Caplan
Minister of Health
10th Floor, Hepburn Block
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Toronto, Ontario
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Dear Mrs. Caplan,

I am pleased to submit to you the report of the Provincial Community Mental Health Committee.

This report is an action plan which will lead to the development of a community-focused, integrated mental health care system in Ontario. It will require commitment, human and financial resources, cooperation and collaboration at the community and provincial level. It will result in mental health care being provided to meet individual and local needs, and help people with serious mental health problems participate more fully in community life, by providing care and support as close to home as possible.

Our report provides local communities and the provincial government with the tools to develop multiyear plans and develop local solutions to local problems. Through the District Health Councils, we are proposing that plans be developed to provide a full range of essential functions in each district.

This will require local definition of roles to be played by hospitals, community-based services, consumers and their families. The District Health Council can and should be the vehicle to bring these interests together.

At the same time, your Ministry will want to support and monitor planning and implementation across this province to ensure that efforts are directed toward the achievement of the goals we are proposing for the mental health system. Financial, program, organizational and legislative initiatives are required between now and 1995 to move us forward.

.../2

Our travels and meetings across the province have demonstrated that rather than being half empty, the mental health glass is half full. We hope that action based on this report will carry us the rest of the way.

I want to personally thank committee members for the insight and dedication they brought to the task as well as the hundreds of people and organizations who took the time to share their views with us.

Thanks are also due to the Research Group members whose patience and hard work turned our ideas into the report we are submitting today.

Finally, I want to thank you and your staff for your support of our efforts. We have appreciated the opportunity to serve.

Yours truly,

Robert Graham

Robert Graham, P.Eng.
Chairman

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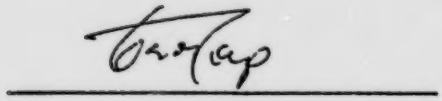

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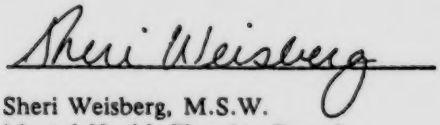

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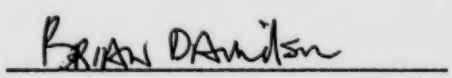

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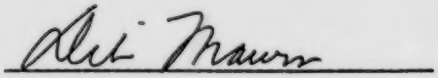

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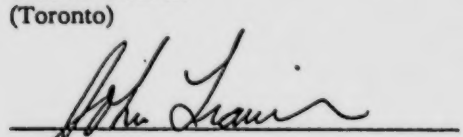

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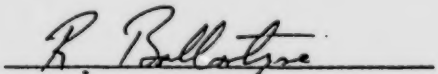

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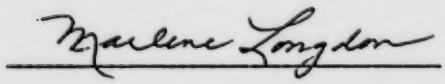

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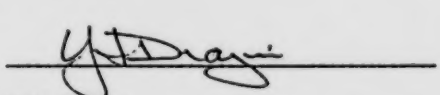

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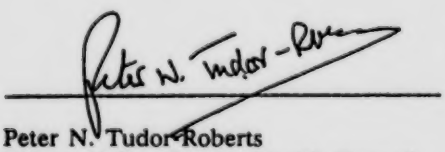

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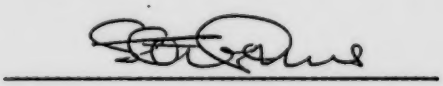

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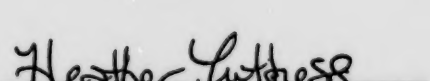

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SUMMARY AND RECOMMENDATIONS

Introduction

In October, 1987 the Minister of Health formed a Working Committee under Mr. Robert Graham to develop a framework for the delivery of community mental health services in Ontario.

The Committee's terms of reference were to:

a) define what constitutes a comprehensive community mental health care delivery system;

b) develop guidelines and standards for various program models, for example, housing program standards or what constitutes a vocational rehabilitation program;

c) develop service delivery models for use in urban centres, rural settings, and remote areas; and

d) advise the Minister on the initiatives required to meet the needs of special target populations including women, youth, the elderly, ethnic and Native groups.

In order to prepare its report the Working Group reviewed previous reports pertaining to mental health care in Ontario. Literature on the experiences of other jurisdictions was reviewed as was material on the financing of mental health care since 1979. With the cooperation of District Health Councils, the Committee met with service providers, consumers and other stakeholders in each region of the province to collect first hand perspectives on local issues, problems and potential solutions. As well, the Committee reviewed 152 briefs and letters it received from people across the province.

Findings

Over the past 10 years, a wide range of community-based programs have been developed in Ontario. Not only do these programs demonstrate the characteristics (flexibility, responsiveness and innovation) identified as being necessary components of a successful community-based system of care, they form a base on which to build a fully integrated mental health care system. Program providers and District Health Councils throughout the province demonstrated their commitment to developing such a system; one characterized

by localized plans within the context of, and supported by, an overall provincial strategy and adequate resource base. Written submissions and presentations from consumers of mental health services and their families demonstrated a vision for the delivery of services to meet the diverse needs of heterogeneous client populations that use community mental health services.

These findings support the provincial government's current policy to fund community mental health services and acknowledge the progress made since the Heseltine Report of 1983. Since 1985 there has been a 65% increase in funding for community mental health programs: the Premier's announcement (August, 1987) to double community mental health spending by 1990 followed the recommendations made by the Evans Panel (June, 1987) and other groups to enhance the capacity of local communities to provide more community-based care.

Some problems, however, continue to exist. Most of those identified by this Committee corroborate the findings of many reports commissioned by or submitted to the Ontario government since 1979, namely:

a) a lack of clear policy regarding who is to be served and how services are to be provided;

b) a lack of a systems approach;

c) a lack of a multiyear plan;

d) little coordination;

e) disparities in the availability of services across the province; and

f) gaps in service.

While funding for community mental health services has increased in dollar terms, it has declined in percentage terms relative to other areas of spending. The same can be said of mental health spending in general. Given the increasing demand and need for services, this trend should be examined if the goal of developing a comprehensive community-focused mental health care system is to be realized.

This report is a directional paper for mental health. It presents a plan for the development of a comprehensive mental health care system. It outlines strategies for action at both the provincial and local levels that will move us closer to attaining the goal of a mental health care system that:

1) ensures that all residents of Ontario have equal access to the mental health services they need in, or as close to, their own community as possible;

2) is consistent with the principles outlined in the Report of the Ontario Health Review Panel of:

   a) **joint participation** of individuals, organizations and governments;

   b) **a concept of health** that includes the totality of an individual's well being and addresses the determinants of quality of life as well as quality of care;

   c) **an integrated** government policy for health; and

   d) **a balance** of province wide and local perspectives which provides for flexibility, pluralism and innovation.

The Problem

Mental illness affects people from all walks of life causing them and their families considerable hardship. According to Statistics Canada and the Canadian Mental Health Association:

a) one out of every eight Canadians can expect to be hospitalized for a mental illness at least once during his or her lifetime;

b) suicide was the second most frequent cause of death among Canadians between the ages of 15 and 39;

c) mental illness was the second leading category in general hospital use among those aged 20–44 years.

According to a review of prevalence prepared for this report:

a) one and one half million people living in Ontario have some form of mental illness; 38,000 are severely disabled by schizophrenia, affective disorders and other mental illnesses (4.1 per 1,000 population);

b) over the next 25 years we can expect a doubling of mental disorders for the elderly and a 40% increase in chronic functional disorders with little change in the number of acute cases;

c) today in Ontario, two thirds of psychiatric patients are admitted to inpatient units for less than two weeks; 90% stay for less than a month.

It is the conclusion of this Committee that mental health care must be focused in the community. Ontario's mental health care system should provide a comprehensive range of services and support to people as close to their homes

as possible. Such a system must be able to address a broad range of mental health needs. Our Committee has concluded that priority must first be given to helping people with serious mental illness or impairment, and to their families.

In developing the principles and components of the proposed mental health system, the issue of prevention was discussed at length. More research is needed to discover causes and cures of mental illness, but this was not the subject of this report. It has been suggested that, given our limited knowledge about primary prevention in the mental health field, efforts should be directed at enhancing individual capacities and competencies to cope with mental illness. Continuing public education and mental health promotion throughout the province should also be encouraged as part of the government's strategy.

To create a comprehensive mental health care system we need to develop, in partnership with consumers and their families, an integrated system of medical and community support services. A multiyear plan is required to balance provincial and local perspectives, while ensuring accessibility and flexibility.

By 1991, each District Health Council should have a mental health plan in place to guide the development, operation and evaluation of local mental health services between 1991 and 1995. This plan should specify the respective roles and links between service providers, and make provision for the involvement of consumers and their families.

The plan outlined in this report for a comprehensive mental health care system in Ontario begins with a **goal statement** that defines the mental health care system in terms of desired outcomes. The **principles** upon which we believe the system should be based are described as are the system's necessary service components or functions.

Recommended **planning activities** at the local and provincial levels are identified and include strategies for joint participation in the planning process of consumers, families, service providers, and volunteers at both levels.

Our plan for a community focused mental health care system has a number of advantages:

a) the principles and functions cover inpatient, outpatient, and community mental health services;

b) it promotes an integrated, collaborative approach to planning and service delivery rather than continued fragmentation;

c) it covers at least 62% of current mental health spending;

d) over time it could lead to the planned reallocation of functions and development of alternative approaches to service delivery;

e) it allows for the local definition of institutional and non-institutional service roles in District Health Council plans; and

f) it allows for the expansion of general hospital bed capacity if consistent with a local plan.

The year 1995 is proposed as the target for the realization of a **community-focused** mental health care system. A period of transition will, however, be necessary. For this reason, it is suggested that between now and 1991 District Health Councils be asked to:

a) develop **long range plans** for an integrated mental health system; and

b) recommend funding for **new or enhanced** community mental health services.

During this period, funding of new or enhanced services should exclude inpatient services and be funded from the commitments made by the Premier in August, 1987. Priority should be given to services that reflect local priorities in relation to the following functions:

a) crisis and residential support;
b) case management;
c) self-help and family support;
d) social and vocational support; and
e) the coordination of local services.

To the extent that local priorities reflect a need for increased **inpatient capacity**, funding would have to come from a source other than community mental health funds. **General hospitals** should seek to fund services defined under the Mental Health Act and Regulations from within their global budgets. The Ministry of Health should endeavour to use this period of transition to fund **demonstration projects** that enhance coordination or linkage, or to test new service delivery models. Local and provincial experimentation and innovation, based on action research and scientific program evaluation, are required and should be encouraged.

The fundamental changes proposed can, and should, be implemented incrementally. The Ministry of Health will need to provide support and resources for local planning and service delivery as well as monitor progress

across the province. It will also be necessary to develop a funding strategy for mental health services in relation to other priorities. Ways in which to improve the communication and cooperation between Ministries and other levels of government with respect to programs and policies affecting mental health care should also be explored.

RECOMMENDATIONS

Recommendation No. 1

That the Ministry of Health adopt the following **goals** for a comprehensive mental health care system as provincial policy.

a) Ontario develop a mental health system to deliver comprehensive services that:

   i) ensure all residents of Ontario access to mental health services in, or as close to, their own communities as possible;

   ii) place priority on providing support to individuals and their families who experience serious or prolonged mental illness or impairment;

   iii) recognize the multi-dimensional nature of the origin and management of mental illness;

   iv) ensure a balance between institutional and community sectors of the mental health system by providing an adequate supply of a range of formal and informal supports and treatment in order to reduce the need for institutionalization, in response to geographic and population needs;

   v) enhance quality of life as well as quality of care by maintaining people in the community and close to their natural environments; and

   vi) provide access to adequate incomes through work or social assistance.

b) Ontario's mental health system provides for:

   i) a partnership between consumers, their families, service providers and government in the planning, development and delivery of services;

ii) improved communication and cooperation between Ministries and other levels of government;

iii) a balance between province-wide perspectives and local priorities that encourages flexibility and community innovation; and

iv) the integration of services provided by health professionals, community agencies, general hospitals and provincial psychiatric hospitals.

Recommendation No. 2

That by 1991 each District Health Council have a **Mental Health Plan** which sets out how the following essential functions will be provided in each district:

i) **Identification;**
ii) **Treatment and crisis support;**
iii) **Consultation;**
iv) **Coordination;**
v) **Residential support;**
vi) **Case coordination and case management;**
vii) **Social support;**
viii) **Vocational support;**
ix) **Self-help/peer support;**
x) **Family support; and**
xi) **Advocacy.**

Recommendation No. 3

That the following principles guide the development and funding of mental health services. Initially these principles should be applied to new or enhanced community mental health services reviewed for funding by District Health Councils between now and 1991.

And that by 1995, mental health services provided by community agencies, general hospitals, psychiatric hospitals and other professionals reflect the following principles in order to qualify for funding:

- **Focused in the community:** Care is provided in such a way so as to enable individuals to obtain needed support and encourage them to make use of family, friends, and other naturally occurring helping relationships. A broad cross-section of the community including

consumers and their families, should have direct input into the planning, development, ongoing operation and evaluation of services.

- **Mandated:** Communities and government share the responsibility to ensure that a full range of services is provided.
- **Comprehensive:** A range of services will be available to meet diverse needs and provide for consumer choice about how needs are met.
- **Individualized:** Care is particular and appropriate, planned with and for the individual and his family and directed toward enhancing individual participation in community life.
- **Flexible:** Services should be adaptable and responsive to the special needs of identified individuals, groups and communities, and to changing needs over time.
- **Accessible:** Services should be provided in such a way so as to ensure that they are available to those most in need and that individuals will not experience significant difficulties in using them.
- **Coordinated:** The service system must provide for the continuity of care and ensure that integration takes place at the client, program and system levels.
- **Accountable:** Supports and services should be monitored, evaluated and adjusted in order to remain appropriate and responsive to changing client needs. Consumers, family members, as well as service providers, are involved in the development, operation and evaluation of services.
- **Culturally and geographically relevant:** The dimensions of a service system must reflect the unique characteristics of specific communities and target populations within them.
- **Functionally equivalent:** Services are developed with the recognition that a variety of service interventions can meet the same need.
- **Use of natural and informal supports:** Self-help approaches and natural support systems (that is, family, friends, community) are essential to the maintenance of mental health and to the treatment of mental illness.
- **Effective:** The mental health plan will encompass more than the narrow range of traditional services. Services will be evaluated in relation to their effects on quality of life as well as outcome measures.

Recommendation No. 4

That by 1991 District Health Councils develop **multiyear plans** for the provision of mental health services in each district that:

- detail the services to be provided **by 1995**;
- set measurable **objectives** in relation to the establishment and operation of services that embody the above mentioned principles and are organized according to the functions of a comprehensive mental health system;
- ensure that the **roles** of general and psychiatric hospitals are clearly defined and integrated in relation to the provision of services under the plan, and identify specifically the means for the development of linkages between hospitals, community mental health services and other community services;
- reflect the full **participation** of consumers and family members as well as essential service providers in the planning process;
- have a **mechanism** to assess needs, recommend reallocation of resources and change the type of services offered so that the service system is responsive to changing needs and reflects the objectives of the plan; and
- include an **annual report** on progress to date vis-a-vis plan objectives, and recommend new funding initiatives in relation to the plan.

Recommendation No. 5

That the Ministry of Health direct each of the **provincial psychiatric hospitals** to develop a plan outlining the development of their programs until 1995. These plans should be developed in cooperation with District Health Councils and Area Mental Health Advisory Boards and should include:

- a description of hospital and community-based programs;
- an outline of how these programs are linked with existing community programs and agencies;
- a statement as to how they will be coordinated with local planning initiatives; and
- an estimate of the proposed impact on bed utilization.

Recommendation No. 6

That by 1989 District Health Councils develop a priority list for the funding of new or enhanced community mental health services to reflect the essential functions outlined in this report.

Recommendation No.7

That the Ministry of Health establish **Area Mental Health Advisory Boards,** comprised of a representative from each District Health Council, to coordinate the development of mental health plans by District Health Councils and other groups to:

- assist in developing a more balanced mental health system through the integration of the roles of psychiatric and general hospitals with community-based organizations; and
- develop strategies for more detailed investigations and make recommendations on those special target groups such as youth, the elderly, ethnic groups, Natives and other special needs groups which, due to the limited time frame, have not been explored in sufficient depth in this report.

Recommendation No. 8

That the Ministry of Health develop a **multiyear plan** for the financing of mental health services which sets out the funding to be available for the enhancement and development of community mental health services on an annual basis between now and 1991. The plan should specify the amounts required by year to implement an integrated community-focused mental health system between 1991 and 1995 and identify funding mechanisms required.

Recommendation No. 9

That the Ministry of Health notify District Health Councils, before **funding** submissions are requested, of the amount of money likely to be available in each district for the enhancement and development of services under the mental health plan.

Recommendation No. 10

That the Ministry of Health use the Health Innovation Fund to support **demonstration projects** related to coordination and new models of service delivery in order to develop a more integrated and innovative mental health care system. Projects to be considered could include:

- establishing local mental health authorities;
- encouraging joint ventures between psychiatric and general hospitals and community agencies;
- rural and remote area models of service and coordination;
- using primary care settings such as public health units (PHU's), health service organizations (HSO's) and community health centres (CHC's) to provide community mental health services and primary care to persons with serious or prolonged mental illness; and
- services for people with dual diagnosis and other special needs categories.

Recommendation No. 11

That the Ministry of Health take a leadership role to develop **legislation** to provide for the essential functions related to a community-focused mental health system using a broadly based consultation process.

Recommendation No. 12

That the Ministry of Health establish a **Provincial Advisory Committee** on mental health to:

- promote the recommendations of this report to consumers, families and service providers across the province;
- help establish and review the activities of any pilot projects undertaken to implement the recommendations of this report;
- review the annual reports of District Health Councils, and Area Mental Health Advisory Boards on the progress made with regard to the implementation of a community-focused mental health care system in each of the six planning areas; and
- report annually to the Minister and the Premier's Council on Health Strategy on progress made in relation to the implementation of a comprehensive mental health care system.

Recommendation No. 13

That the Ministry of Health strive to improve communication with and cooperation between the provincial Ministries of Community and Social Services,

Housing, Skills Development, and Corrections as well as federal departments and local governments involved with mental health care programs, policies and funding, including income security.

Recommendation No. 14

That the Ministry of Health support District Health Councils and other planning bodies in the development of mental health plans by providing them with resources to do so.

Recommendation No. 15

That by **January 1989**, the Ministry of Health, in conjunction with the Ministries of Colleges and Universities, Skills Development, Community and Social Services, and Education, develop a mental health training strategy that recognizes the need – particularly in a community-focused mental health system – to provide continuous training and upgrading to a diverse group of mental health service providers with different professional backgrounds and practice settings, including rural and remote areas.

Recommendation No.16

That the Ministry of Health develop a strategy for **applied research and evaluation** in the mental health field, and direct funding of projects in this area.

Recommendation No. 17

That the Ministry of Health develop a strategy to strengthen the presence of mental health professionals in **underserviced areas** by:

- encouraging the development of local mental health workers in Native, Francophone, rural, remote and multicultural communities;
- continuing its efforts to attract both Francophone and Native people into the mental health field;
- providing financial incentives;
- providing professional support, consultation and continuing education; and

- defining specific roles for the province's five teaching centres in providing back-up, consultation, support and student placement.

Recommendation No. 18

To redress the imbalance in the distribution of physicians, the province's **five teaching centres** should:

- place a greater emphasis in psychiatric residency training programs on community psychiatry, care of the mentally disabled and consultation to community programs; and
- ensure that training programs for family physicians include the utilization of mental health services, principles of psychiatric rehabilitation and problems faced by the elderly and minority groups.

Recommendation No. 19

That the Ministry of Health develop a separate funding strategy for mental health promotion and educational activities to ensure that additional resources are available within communities for such projects.

The report that follows can be used as an **action plan** to develop a mental health system that is responsive, comprehensive, flexible and accessible.

SECTION 1

Introduction

A number of events occurred in 1987 that resulted in the need to closely examine Ontario's mental health care system. On August 28, 1987, Premier David Peterson announced that funds for adult community mental health programs would increase from $65 million in 1987 to $130 million by 1990.

The Provincial Auditors' 1987 Report identified a number of problems with Ontario's Mental Health System. Specifically, it stated that "even given (this) significant increase in funding, there is still a serious lack of adequate community services in the province ... better information (from both psychiatric hospitals and community-based programs) is needed to plan and manage mental health care services."

Bill 50, "An Act to Provide Community Mental Health Services", was introduced in December, 1987. This private member's bill proposed legislation to facilitate the development of a comprehensive community-based mental health care system.

With the need for change clearly established and with legislative and financial support for change evident, the Minister of Health appointed Mr. Robert Graham in October, 1987, to chair a committee to make recommendations for the development of a community-based mental health care system. The Committee's mandate was to:

a) define what constitutes a comprehensive community mental health care delivery system;

b) develop guidelines and standards for various program models;

c) develop service delivery models for use in urban centres, rural settings and remote areas; and

d) advise the Minister on the initiatives required to meet the needs of special target populations including women, youth, the elderly, ethnic and Native groups.

The Committee began its work in November, 1987, with a series of seven community consultations (Appendix I). District Health Councils in the six

planning regions were asked to organize the presentations made by mental health service planners and providers as well as family members and consumers. As time did not allow for individual presentations by all interested parties, the Committee also invited and reviewed written submissions (Appendix II). In addition, reports and studies on mental health needs and services, spending and legislation were reviewed.

This report, which was presented to the Minister in July, 1988, contains the findings and recommendations of the Provincial Community Mental Health Committee[1].

Purpose of the Report

The purpose of this document is to enable the Minister of Health to design a policy for the long range development of a mental health service system for the citizens of Ontario.

This report is intended to serve as a vehicle through which the Ministry of Health, in collaboration with local communities, can establish and implement an organized, comprehensive community- focused mental health care system.

Achieving Health for All: The Mental Health Component

Recent reviews of the Canadian health care system (Evans, Spasoff, Epp) identify the need to reduce inequities in access to the health care system, emphasize a community-based system and strengthen each individual's role in maximizing his/her health potential.

These reports identify the importance of mental health in the health equation and recognize the **connections involved between social, economic and physical factors**.

If we are to achieve the goals outlined in these reports, the issue of "mental health for all" must be addressed. The development of a mental health policy for Ontario is crucial to this task.

Traditionally, mental health policy has focused on issues related to mental illness and on the formal mental health care system. Due to structural

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[1] The committee's mandate did not include drug and alcohol problems.

problems, a consistent philosophy and means for developing an integrated approach to mental health service delivery has been lacking. Institutional and community services have developed along parallel tracks. Community involvement in creating healthy environments and supporting the mentally ill has not been fully developed. This segregated approach has not served the needs of those with mental health problems or the mentally ill.

The Committee believes that the system as a whole needs to be examined in order to create an integrated system. Such a system can only be developed from a community-focused philosophy, one in which the needs and strengths of the individual are central.

This report is based on the following assumptions:

1. That a comprehensive mental health care system provides both institutional care and community-based treatment and support services, and provides for essential links between the two;

2. That a system that emphasizes community-focused mental health care services is the best model for strengthening the role of the individual and maximizing his/her health potential;

3. That the mental health care system should on a direct service level, be directed at those who are suffering from mental illness with the greatest emphasis being placed on those who are seriously ill or impaired;

4. That a comprehensive mental health care system encompasses services that are preventative in nature; and

5. That developing a comprehensive mental health care system will require the allocation and reallocation of resources in a manner consistent with a community-based philosophy.

A community-focused mental health care system is a goal that cannot be achieved immediately. It is, however, a service development and delivery system that will, over time, maximize the capacity of its formal and informal components.

This report builds on the principles outlined in Agenda for Action: A Report of the Ontario Council of Health (1979) and on the recommendations of the Heseltine Report: Towards a Blueprint for Change (1983). It addresses the issue of mental health/mental illness in Ontario and assesses current problems. Guidelines for moving the present system in a direction that will achieve "health for all" are suggested. Its implementation relies on leadership,

resources, commitment and cooperation on the part of and between groups involved in the delivery of mental health care services.

Mental Health - Mental Illness in Ontario: Prevalence

Every person has potential to improve his/her mental well being. Issues of mental health range from the negative effects of living in poverty to the chronic, sometimes devastating, effects of major mental illnesses such as schizophrenia, bi-polar affective disorders or Alzheimer's disease.

Mental health problems exist in cities as well as in rural areas: they may be temporary, intermittent or chronic in nature. Obtaining an accurate measure of the extent of mental health problems is, however, difficult.

Canadian studies of the prevalence of major mental disorders are few in number. The best and most recent estimates are found in Bland (1984). His figures indicate that there are approximately 24,000 persons with chronic schizophrenia in the province, and 7,500 with chronic and severe affective disorders. Estimates for dementias are even less available. Applications of data from other countries suggests that there are approximately 25,000 people with moderate to severe dementia, half of whom reside in institutions (Molsa, 1982: 541-52).

A study of The Health of Canadians: Report of the Canadian Health Survey (1981) surveyed the emotional health of 17,492 persons over the age of 15. The study utilized scales that measured positive affect or good feelings about oneself, the world and one's place in it. It also measured negative aspects of emotional health as evidenced by mild affective disorders, notably anxiety and depression. It did not measure incidence of mental retardation or psychosis. The authors reported that 46% of Canadians were more happy than distressed about their lives; 41% had neutral or mixed feelings; and 4% had frequent symptoms of anxiety or depression. Because of methodological limitations, the investigators felt this 4% was an underestimation and that the true prevalence was as much as 10% higher. Of particular interest for planning purposes, were the groups identified as being most at risk to symptoms of anxiety and depression: the "unhappy" Canadian was either young (under 20) or older (over 55), more likely to be female, widowed, divorced, or separated, to have a low income, and a lower level of education (Canadian Health Survey, 1981:131).

Murphy et al (1984), studied the prevalence of depression and its stability over a 20 year period in a Maritimes county. They reported a prevalence rate for depression and anxiety of 12.7%.

Reported prevalence rates of mental disorders in primary care settings vary according to whether the studies use the International Classification of Diseases (ICD) diagnostic criteria or employ a broader, "problems in living", definition of mental disorders. By current standards of what justifies medical intervention, however, it appears that in any given year between 10 and 20% of the population will present to primary care settings with emotional or behavioral problems (WHO, 1973:18).

Data collected as part of the U.S. National Institute of Mental Health's "Epidemiologic Catchment Area (E.C.A.) Study" identified the most common disorders to be phobias, alcohol abuse/dependency, dysthymia and major depression (Myers et al, 1984:959). As these studies are not Canadian and were conducted in primarily urban areas, they must be applied to Ontario with some caution. Based on Ontario's 1986 population of 9.2 million, we expect approximately 1.5 million persons in Ontario have some symptom of a mental illness. Estimates of the more common disorders are presented in Appendix IV.

Individuals with mental health problems often present in primary care settings. Primary care physicians can spend up to 30% of their time handling emotional or psychiatric problems and at least 50% of all psychiatric problems are managed solely by family physicians. This is particularly true in rural areas where psychiatric consultation is limited or unavailable.

Case identification remains an important issue. Lack of appropriate intervention results in increased individual distress, loss of human potential, as well as high utilization of medical resources in primary care settings. Jones and Vischi (1979:VI) reviewed 13 studies examining the question of whether treatment for mental illness reduces subsequent medical care utilization. They found a median reduction of 20%. Although these findings are not without their limitations, they do provide evidence for the benefits of early identification and treatment of mental illness as well as the need for developing models to support family physicians in their role as front line mental health workers.

As a result of the continuing process of deinstitutionalization that began in the 1950's, in combination with improved treatment methods, the majority of people with chronic mental illnesses now live in the community. Leighton (1982:14) states: *"as is commonly the case, the chronically ill individual bears the brunt of changes in mental health policy and practices."* **The seriously mentally ill are among the most disadvantaged members of our society.** The chronic and debilitating nature of these diseases means that these individuals need a multitude of medical and support services to maximize their health potential.

Because the prevalence of major disorders at different ages is known, some predictions about future trends can be made using census data from Statistics Canada. The major future trends will reflect the entry into old age of members of the baby boom which followed World War I and by the entry into the age of chronic major disorders of the better known baby boom of World War II (Humphrey,1982). Over the next 25 years, this will result in a doubling of mental disorders in the elderly (chiefly dementias) and, simultaneously, a 40% increase in chronic functional disorders, with little change (or perhaps a slight reduction) in the number of individuals with acute mental disorders (Humphrey, 1986).

In summary, approximately 1.5 million people living in Ontario have some symptom of mental illness. Based on an estimate of 4.1 per 1,000 population, we expect that 38,000 persons in Ontario have some form of serious mental illness. The remainder experience varying degrees of disability.

Special Target Groups

A number of special target groups are susceptible to mental health problems and/or illnesses. The groups also tend to be disadvantaged in terms of obtaining the services they need. As noted in the Provincial Auditor's Report, a better information system is needed to determine reliable prevalence rates in these groups. The comments presented here reflect the information presented to the Committee by a wide range of individuals, and may have varying levels of reliability. However, they are important starting points.

I. The Chronically Mentally Ill

The deinstitutionalization process has increased the number of persons with serious mental illnesses residing in the community, many of whom are without the necessary resources. Residential Homes for Special Care, provide housing for 1,963 residents, most of whom are former psychiatric patients (Ministry of Health, April 1987). Others live in boarding homes. Many have no direct involvement with mental health professionals.

A mental health consultation service initiated in Hamilton discovered that many boarding home residents had been doing virtually nothing for years: their medical condition and/or treatment had not been reviewed recently or regularly. Case managers were instrumental to improving the level of care for these individuals.

Some persons with chronic mental illness are homeless. In 1986, it was estimated that homeless former psychiatric patients numbered at least 12,000

(Housing Policy Review Committee, City of Toronto: 1986). These people are particularly vulnerable due to the nature of their illness. Their income is usually at a subsistence level and they frequently encounter barriers when accessing much needed services provided by a complex mental and medical health care system. At times, they may reject services due to either the symptoms of their illness or because of a desire for treatment of a less medical nature. This group requires the widest range of services and needs assistance to access services that are essential to effective treatment and rehabilitation.

II. Native Populations

According to Statistics Canada (1981), Ontario's population includes approximately 110,000 Native persons. About half of them live on reserves. Six out of ten Natives in Canada give English as their first language. There is a higher proportion of young people and fewer elderly than in the general population. They are more likely to live in rural areas, have a higher unemployment rate, lower incomes and less education than non-Native populations. In addition, a poorer standard of housing and a higher incidence of single parent families is noteworthy. Many of these socio-economic variables are associated with increased rates of mental health problems.

The suicide rate is high in Native groups - four times the Canadian average. Family violence and alcoholism are major problems. The stress of adapting to a changing culture is evident, particularly in the 16 - 35 year old age group.

All areas visited expressed concern about providing culturally relevant mental health services to their Native populations. The issue of jurisdiction for Indian services was identified by presenters (Thunder Bay and Cornwall) as one that creates problems for service development. The lack of trained Native mental health professionals was another barrier to service as was the remote location of some groups of natives.

The Sioux Lookout Zone Hospital is one example of a mental health service that provides care to a remote area inhabited, primarily, (12 - 15,000) by Native Canadians. It is accessible mainly by air. An innovative program of training Native paraprofessionals has been developed. Professionals providing services to Native populations would benefit from establishing a network for sharing problems as well as solutions.

III. Youth

Providing mental health services to children and adolescents has alternately been the responsibility of the Ministries of Health and Community and Social

Services. Many presenters expressed their concern about the artificial split along the dimension of age. This concern is particularly relevant in smaller urban and rural areas. Some towns have been progressive in arranging for shared facilities, and in a number of instances, shared funding.

Of particular concern is a group of young people (ages 16 -24), who are now known as transitional youths. Within this population are some young people who are severely disturbed and may already be considered part of a chronic population. In Metro Toronto, transitional youths needing mental health services is estimated at 24,000. Many of these youths never reach a service that could help them (Lowery: 1987).

The Ontario Association of Children's Mental Health Centres stressed the need for specialized services for this group, and for increased collaboration between the Ministries of Health and Community and Social Services. Some of the service issues identified by presenters were: barriers created by age restrictions; lack of specialized resources; unequal geographic distribution of resources; the division of responsibilities; and, sometimes, the lack of co-ordination of services provided by Ministry of Community and Social Services and the Ministry of Health. They state that accessibility to services is crucial. Long waiting lists currently exist, and delays in treatment exacerbate the problem.

IV. Dual Diagnosis

Of particular concern in the development of mental health services are the needs of those affected by more than one disease or disability. Individuals with a "dual diagnosis" are those who, for example, have a primary diagnosis of a developmental disability with an emotional/psychiatric disturbance as a secondary diagnosis. It is estimated that in Ontario this group numbers approximately 6,800 adults. These figures represent only those most seriously affected. With a less restrictive definition of dual diagnosis, the number of individuals would be much higher (Ontario Ministry of Community and Social Services, 1987).

Also, persons with emotional problems and mental illnesses frequently present with problems of alcohol/substance use or abuse. It is not uncommon for these persons to fall between the cracks of mental health and alcohol/drug treatment programs. Coordination and collaboration in assessment and treatment of these individuals is essential.

Another category of the dually diagnosed are those affected by physical impairments. We received a presentation from the Canadian Hearing

Society. According to the Society there are over 600,000 hearing impaired persons in Ontario. The group noted it was difficult to obtain assessment and treatment services for the hearing impaired.

Accessibility to mental health care services by persons with physical impairments is an area of concern for those planning a comprehensive service. Specialized services must be developed or mainstream services adapted to provide accessible and sensitive services.

V. Cultural Groupings

Ontario has a diversity of cultures and languages including the two official groupings of French and English. In many areas, Italian, German, Chinese, Portuguese, Polish, and other cultural groupings are highly represented (Statistics Canada, 1981).

Many members of these cultural groups are new Canadians for whom the experience of immigration and its related stresses may contribute to higher rates of mental health problems. The manner in which these problems may present also differ. Accurate assessment of problems, as well as appropriate and acceptable mental health interventions, are essential both for new immigrants and other members of ethnic communities. Wherever possible, therapists with similar cultural backgrounds should be available to treat these individuals.

Multicultural groups such as the Multicultural Mental Health Group (Toronto) and the Hong Fook Mental Health Association, stressed the need for services that are culturally and linguistically relevant. They cite, from 1981 Census figures, that, in Toronto, 30% of the population did not list English as its mother tongue.

Representatives of our Francophone communities emphasized the importance of being able to receive mental health services in their own language and indicated that "expressing feelings in another language is difficult." Although culturally specific services may not be feasible in every community, multicultural agencies may be able to facilitate access, provide consultation and educate mental health professionals. In certain instances, targeted programming geared to specific groups may be required.

Each District Health Council should carefully assess its community's cultural composition and include in its plan, the means for providing culturally relevant services.

VI. The Elderly

Statistics Canada (1981) reported that 10.1% of the population of Ontario was over the age of 65. This percentage will increase in the decades to come. With it, will be an increase in mental disorders in the elderly.

Because of the changing structure of our society, many of our senior citizens are without the support of an extended family network. The behavioral problems associated with disorders such as Alzheimer's disease require innovative mental health services to support family caregivers and to help patients remain in the community as long as possible.

Many District Health Councils have already begun to estimate the needs of this population and plan appropriate services for it. Even in urban areas, professionals with expertise in geriatric psychiatry are now in short supply.

In the Niagara region, the District Health Council report on geriatric psychiatry services states that *"20 to 30% of the elderly suffer from some type of mental disorder, in particular depression, inappropriate use of over the counter and prescription drugs, alcohol misuse and, in the case of men, suicide"* (Niagara District Health Council, 1985).

The report stresses the need for community and family support services, as well as alternatives to institutionalization.

Crucial to developing adequate geriatric mental health services for the province will be the education or re-education of health professionals. Family physicians will play a vital role in the management of the "frail elderly" and will require education about psychotropic drugs and access to psychiatric consultation.

VII. Women

Women seek mental health services more frequently than men. This is not surprising when we consider the fact that more women are single parents, live in poorer accommodation, and have lower incomes. Although roles have changed somewhat in the last few decades, women are still more likely to be responsible for the physical and emotional care of their children.

Because of the stresses of the conditions outlined above, many women require and seek mental health care and have a disproportionately higher number of hospitalizations than men do. Many of these women report that the mental

health system is not responsive to their needs and that services are not easily accessible. The lack of available and affordable child care, for example, makes it difficult for many women to attend mental health programs or appointments for therapy.

Efforts of the various government Ministries to improve the economic status of women through work programs and adequate benefits are essential to the mental health of women and their families. As children and as adults, women are often the victims of violence. More counselling programs and support services addressing this issue are needed.

While mental health services for women have been developed in recent years, more needs to be done to ensure the accessibility and responsiveness of these programs.

VIII: The Mentally Ill Within the Correctional System

There is a higher prevalence of mental illness in people residing in Ontario's correctional institutions than in the general population. A number of these people remain undiagnosed or receive little active treatment while incarcerated and frequently are not referred to appropriate services when they are released back into the community.

The Urban/Rural Dilemma

The main thrust of the recommendations in this report is the redirection of mental health services towards a community-focused, community-determined mental health care system.

Whether the community is urban or rural, the principles that direct the system and the components required for a comprehensive mental health system are the same. What is different are the characteristics of the community itself. These influence not only how the problems may present but how the components of the system are developed and delivered. Some of these characteristics create very real problems for the development of services and will require innovation, experimentation and cooperation.

The following characteristics of rural and urban areas were highlighted in numerous presentations to the Committee:

Rural Characteristics

1. Large areas with low population density;
2. Poor or non-existent public transportation systems;

3. High unemployment, low average income;
4. Fewer community resources (both services and manpower);
5. A tradition of independence governs attitudes toward mental illness and utilization of mental health services;
6. Higher visibility, less anonymity for both clients and service providers; and
7. Isolated and underserved Native populations especially in remote areas.

Urban Characteristics

1. Smaller, high density areas;
2. Pockets of high unemployment and poverty;
3. Specialized resources more available but may not always be directed at high priority groups;
4. Cultural diversity;
5. Homelessness;
6. Large number of uncoordinated services; and
7. A concentration of chronically disabled persons.

These issues have implications for the recruitment and training of health professionals, the development and funding of service components and for the planning and coordination of the system on both a local and provincial level. The second section of this report deals more extensively with these issues.

Moving Toward a Community-Focused Mental Health Care System

In the early 1900's, mental hospitals were the major site of treatment and care for the mentally ill. In the 1950's, therapeutic advances in the form of medications and new treatment philosophies resulted in a flow of patients into the community. Changes, in terms of the development of social services and welfare programs, universal health care and the development of psychiatric services in general hospitals were expected by planners to assume much, if not all, of the burden of care for the mentally ill previously carried by mental hospitals.

General hospital psychiatric units were, however, frequently treating populations that were non-disruptive and who could be quickly discharged. The severely and chronically ill continued to be treated in the provincial psychiatric hospitals (Heseltine, 1983:27).

Heseltine (1983:81) found that although more persons with psychiatric disorders were residing in the community, up to one-third of the patients in psychiatric

hospitals did not need to be there for treatment purposes but lacked other appropriate accommodation. Once discharged from hospital, however, patients tended to cluster in cities where more community resources existed.

The creation of universal health care insurance, as well as a downturn in the economy and its accompanying life stresses, added to the demand for mental health services. At the same time, changing public attitudes toward emotional problems, psychotherapy and psychoanalysis, in conjunction with the increased availability of services under OHIP led to the increased utilization of mental health services by those persons who, previously, would not have used a mental hospital.

The result was an explosive increase in the numbers using mental health services and drawing on mental health dollars. Each person's share of the services inevitably became smaller and smaller as the system moved away from institutional services for a relatively small number towards a broader range of services for more than four times as many people.

During the same period, resources and funding of mental health services increased overall, although not sufficiently to meet the increased utilization of services. As the subsequent demand increased, communities became less able to support persons with mental illnesses in the community. As a result, the rate of re-hospitalization of persons with serious mental illnesses increased.

The creation of the Adult Community Mental Health Services Program in 1976 was a positive step toward meeting the need for locally based care and support of the mentally ill in the community.

Major problems, however, still exist within the health system as a whole and are reflected in the following analysis of mental health spending. This analysis is based on documents published by the Ontario government, specifically: Regional Allocation of Estimated Expenditures of Mental Health Services by the Ministry of Health (1983-84, 1984-85, 1985-86) and Expenditures Estimates 1987-88 published by the Management Board of Cabinet.

1. The total spending for mental health services (1985/86) was recorded at $910,383,111.
2. Community mental health spending accounted for $41,379,177 or 4.5% of the total.
3. Community mental health spending increased by 65% between 1985 and 1988. It is now estimated at over $65 million and is expected to double to $130 million by 1991.

4. Although spending on community mental health programs has increased since 1979, it has actually declined as a proportion of Ministry of Health and overall government spending.

5. The proportion of mental health dollars spent on medical and hospital services has increased while the proportion spent on community mental health services fell between 1979/80 and 1985/86. Hospital and OHIP funded services represented 82.72% of mental health spending. This hike was caused by the increase in the OHIP share of mental health spending which rose from 14.3% to 21.5% of the total. Combined expenditures for general and psychiatric hospitals declined from 66% to 61% during the period under review.

6. Spending on serious mental illness has increased at a slower rate than has total spending on mental health, and is declining as a proportion of expenditures.

7. Per capita spending on community mental health programs was $4.51 in 1985/86.

Establishing Priorities

In a time of changing population needs and limited resources, difficult decisions will have to be made regarding the allocation and reallocation of resources to meet mental health care priorities in a manner consistent with a community-focused philosophy.

Defining priorities is a difficult and complex process. The Georgia Model, the British Columbia Model and the recent guidelines developed by the U.S. National Institute of Mental Health have been instructive. Parameters most frequently include aspects of diagnosis, duration and disability. The Committee suggests the following as a guideline for the development and delivery of mental health services:

First priority: Persons at high risk for psychiatric hospitalization who are suffering from a defined psychiatric illness and whose illness frequently requires the widest range of therapeutic and support services (for example, schizophrenia).

Second priority: Persons with significant dysfunction in one or more areas of life. This group may include those who, due to an acute life experience (grief, job loss, marital breakdown), present with symptoms of mental illness and those who, due to the

chronic nature of their mental illness, require mental health services to maximize their health potential. In the first instance, crisis services and short-term therapy may be needed. People with chronic illnesses may require a more extensive range of components in order to re-integrate into the community.

Third priority: Persons with mild to moderate emotional problems. These people present with symptoms of distress (physical and psychological) that prevent them from functioning in at least one major area of their lives. These people usually approach their family physician for support.

Fourth priority: "Healthy" individuals seeking personal growth and self-enrichment. Resources permitting, attempts should be made to identify effective primary prevention interventions for enhancing coping skills and increasing well-being. Extensive and expensive (government funded) treatment for the "well functioning individual" should be a low priority.

Problems in the Current Mental Health System

From 1970 to the present, numerous reports have been undertaken to study mental health services in Ontario. Common themes are evident in these reports and can be summed up in the principles presented in Agenda for Action: A Report of the Ontario Council of Health (1979). The authors of this report, members of the Committee on Mental Health Services in Ontario concluded that, *"many aspects of the mental health services continuum require attention"*, and identified two levels of responsibility for mental health services:

1. Centrally, the provincial government has overall responsibility for ensuring adequate funding, availability and equitability of services that meet defined standards. This responsibility includes that of encouragement and assistance to communities in the identification and planning of mental health services.
2. In contrast, responsibility for the delivery of locally required mental health services must be decentralized. Communities, mental health facilities and the professionals within them, bear this responsibility.

The principles contained in Agenda for Action were developed through an extensive consultation process and still reflect current thinking about mental

health services. It was followed by a discussion paper, Towards a Blueprint for Change: A Mental Health Policy and Program Perspective (Heseltine, 1983). Heseltine's recommendations were designed with two fundamental goals in mind:

1. A balanced and comprehensive mental health care system.

   Heseltine explains that *"balanced means a distribution of resources so that the required range of services is as available to persons who do not need an inpatient setting for treatment, care and support, as it is to persons who do need an inpatient setting. It is important to strive toward a mental health care system which emphasizes non-institutionalization, which directs energy and resources toward providing services outside the hospital so that hospitalization occurs only when dictated by treatment or behavioral needs.*

2. A separation of treatment and accommodation.

   ... We should not be admitting people to hospital unless they need an inpatient setting for specific treatment or for behavioral problems. This goal has already been accomplished to some considerable degree through the extensive deinstitutionalization of provincial psychiatric hospital patients over the past 15 or so years. However, the early period of deinstitutionalization was not accompanied by a sufficient emphasis upon the provision of alternative support services, including accommodation, with the result many patients discharged into the community experienced difficulty. Despite the marked improvement in the availability of these services in the last two years we have a lot of catching up to do.

   ... An essential corollary of deinstitutionalization and non-institutionalization is the provision of alternative settings for treatment and care in the least restrictive and disruptive settings which are as close to the patient's or client's home as practical" (1983:205).

The Heseltine Report took a strong position on the development of alternative and communitybased mental health services.

The issues of planning and co-ordination, range of services and resources raised by Heseltine will be discussed in relation to verbal and written presentations to the Committee.

A. Planning and Coordination

Planning and coordination are perhaps the most common themes of concern in the mental health field. The Committee on Mental Health Services in Ontario (1979:136-7) concluded:

"clearly lacking is a formulation of government policy and priority, publicly stated, regarding mental health and mental illness services relative to other provincial projects, plans and programs. Once more, without policy there can be no target for achievement, no measurement of success or failure. The policy must reflect the province's priority in this matter, and that can only be ascertained through some public/professional/government consensus."

Since that time, and as a result of a recommendation of the Heseltine Report, mechanisms for planning on a local level have been put in place through the District Health Councils. The Councils' Mental Health Task Forces have been asked by the Ministry to develop a three year plan for mental health services in their areas. Most District Health Councils have now completed their plans. On a central level, the Mental Health Division, through its Mental Health Planning Branch and Adult Mental Health Services Program, develops plans for provincial psychiatric hospitals and community mental health programs. Major reviews and planning processes such as A Proposed Model for Northeast Mental Health Services and the Whitby Redevelopment Project have been undertaken.

Developing a plan for mental health services is complex due to the number of its components, many of which are not under the direct authority of the Mental Health Division or, for that matter, the Ministry of Health.

The Committee heard the following regarding mental health planning during the community consultation process:

Commitment – *"Strong leadership at the Ministerial and Ministry levels is needed. Mental health care has to be a stated priority"*

Written policy – *"We need to know what the Ministry's plans and priorities are in order to effectively develop our local plans."*

(Cornwall)

Plan for equitable distribution of resources – *"We need a Ministry level plan that acknowledges urban/rural differences."*

Multi-year plan – *"A multi-year plan is essential, if we know funding commitment a number of years ahead we can more effectively recommend yearly priorities and plan ahead."*

The client as the base for planning – *"We need a Ministry level plan that is compatible with local and client needs."*

(Chatham)

A clear mandate for the Mental Health Branch – *"All three sectors (hospitals, community and institutions) need to be more closely tied together in planning."*

(Guelph)

Inter-Ministry policies – *"Plans for mental health services that involve more than one Ministry need to be clearly stated. The Ministry of Health needs to be proactive in establishing these plans."*

(Toronto)

Provincial data base – *"We need a better information system in order to plan."*

Model for needs assessment – *"We need a more effective needs assessment tool, one that not only identifies what is needed, but how much and what might be the best model."*

Inter-Ministry planning – *"Inter-Ministry planning is essential, particularly in relation to transitional youth, housing and transportation. Joint funding of projects would be helpful."*

Consumer involvement – *"Another concern I have ... is that we all talk about getting consumer input. And we mean it. But we have never figured out how ... and we have no mechanism or even useful ideas on how to involve them."*

Summary

At the present time there is no provincial policy that informs mental health service development and delivery. The current system has resulted in:

a) a base of over 400 community-based programs; and

b) an increased awareness of local needs and perspectives through the use of District Health Councils.

It does not at the present time provide for:

a) long range integrated planning;

b) adequate involvement of consumer and family groups;

c) adequate accounting for urban and rural variations in needs;

d) setting priorities within the system;

e) adequate inter-Ministry planning; and

f) a plan for continued community involvement that involves the provincial psychiatric hospitals and other Schedule 1 Facilities.

B. Services/Components

The formal mental health system in Ontario consists of institutionally based services in the psychiatric and general hospitals, and community-based mental health agencies. Mental health services are also delivered by various professionals in private practice. Family physicians can spend up to 30% of their time handling emotional or psychiatric problems and at least 50% of psychiatric problems are managed solely by the family physician. In general, the smaller the community , the more likely the family physician is to assume responsibility for the treatment of the mentally ill and referrals to other mental health services.

These formal mental health services are supported by a host of social and volunteer agencies, families and self-help organizations.

The Community Mental Health Branch funds over 400 mental health and drug/alcohol programs in the province. These programs are operated by two different types of organizations: nonprofit voluntary groups (48%) and general hospitals (52%).

The non-profit sector consists of a mixture of programs ranging from small, independent, volunteer board run programs to those run by associations like the Canadian Mental Health Association. More services tend to be provided in the areas of accommodation and psychosocial services than in medical or mental health treatment.

The general hospital sector, through its psychiatric units, operates a variety of out-patient services. Some of these are traditional clinical services, others have been innovative in moving their activities (assessment, consultation, education) out into the community. Examples would be on-site consultations in family doctors' offices, home visits for assessments and treatment, and joint projects with community agencies. Where general hospitals have been able to embrace a community-based philosophy and work collaboratively with community agencies, treatment and rehabilitation capacities have been maximized.

General hospital psychiatric units have had some problems in moving toward community-based programming. Some attribute this to an inherent institutional

bias, others believe the problems are due to insufficient resources. The Committee heard differing opinions as to the appropriateness of hospitals operating community-based mental health programs.

The provincial psychiatric hospitals operate out-patient programs for discharged psychiatric patients. The format of these and the extent to which they embrace a community philosophy varies from institution to institution. Hamilton Psychiatric Hospital, for example, has moved toward community-based programming by seconding staff to other community-based mental health agencies.

Components of the system must be coordinated if services are to be delivered effectively. Continuity of care involves the provision of the appropriate type and level of treatment and support services to the individual who is mentally ill. A coordinated approach to treatment helps the individual maintain himself/herself at the highest possible level of independent functioning and thereby prevents, or reduces, unnecessary hospital admissions or readmissions (Heseltine, 1983:223). In many areas of the province there is little co-ordination between hospital and community programs.

In the provincial hospital sector this problem is, in part, due to their historical role as custodial institutions. It is also due, in part, to a lack of clear policy direction and resource capacity to shift their focus to community-based alternatives. Added to this is the problem of co-ordination associated with the physical distance between the hospitals and the communities they serve.

The extent to which services are available, how they are organized and delivered, and by who, varies greatly throughout the province. The nature of problems being addressed by the mental health system also varies extensively. While there is a general division along the lines of mental illness/social problems between the Ministry of Health and the Ministry of Community and Social Services, some overlap occurs in regions where one of the components is not represented and in the area of OHIP billings for psychotherapy for well-functioning individuals.

In a province as large and diverse as Ontario it is difficult to describe, in detail, the structure of the mental health system. Geography alone creates different service delivery problems for urban and rural areas. In rural areas, transportation and access to services are major problems. In contrast, a city like Toronto has unique organizational problems due to its size.

Rural areas often lack psychiatrists even when financial resources are available. The lack of other trained mental health professionals is also a

problem. This results in existing personnel being stretched to meet the demand for services and subsequent problems with burnout. Attracting, keeping and retraining personnel in rural areas is a long standing problem that, to date, has been resistant to corrective interventions. In urban areas, although trained mental health professionals exist in abundance, they frequently are not working with the seriously mentally ill.

The Committee heard the following regarding the continuity of care and range of services:

Accessibility – *"We want services to be as close to home as possible. We acknowledge that this is sometimes difficult in rural areas and would like some help on how to resolve this problem."*

(Thunder Bay)

Hospitals part of community-based system – " *... the distinctions between hospital/institution-based and community-based services are not useful."*

(Thunder Bay, Cornwall, Chatham)

Informal supports – *"Coordination and cooperation are what we, as parents and family members, prize because they help our sons and daughters and spouses the most. We are part of the support system."*

(Guelph)

Advocacy – Advocate groups stressed the importance of their function in ensuring quality care for persons with mental illnesses.

Quality of life – *"What we need as patients is decent and affordable housing, an opportunity to work and to be treated with respect."*

(Oshawa)

Transportation – Transportation was another issue raised consistently throughout the province. This was particularly stressed in rural areas where programs are often great distances from a person's home and where virtually no public transportation is available. In cities, the cost of transportation for someone with a subsistence income means people are unable to get to the programs they need.

(all areas)

Crisis services – Crisis services were identified as a major deficit in the province. Other shortfalls include training of staff, mobility of the service, and crisis-type shelter to avoid hospitalization.

(all areas)

Waiting lists – People acknowledged that services were much more available than a number of years ago but now, the waiting lists at some agencies have become prohibitive at times resulting in unnecessary hospitalizations.

(all areas)

Transitional youth – The needs of "transitional youth" were highlighted by presenters. This group was seen as falling between the cracks as they moved from the service system for children to that for adults. Waiting lists for this age group, too, are high.

(Toronto)

Vocational services – Vocational rehabilitation services suitable for the mentally ill are largely unavailable in most regions.

Cultural relevance – *"We firmly believe that a comprehensive community mental health system must include linguistically and culturally appropriate services which are accessible to people of diverse cultural and racial backgrounds."*

(Toronto)

Hearing impaired – *"When emotional or psychiatric problems arise, deaf persons have a very limited set of options. Although deaf people residing in Toronto can approach CONNECT, a community mental health service for deaf and hard of hearing adults recently funded by the Ministry of Health, those outside of Toronto have almost no resources at all."*

(Sudbury)

Native population – The needs of our Native population were highlighted throughout the province. The model of training Native persons to provide mental health services, particularly in remote areas, seems a promising approach.

Cooperation – Some presenters identified that "territoriality" interfered with developing and delivering effective services.

Collaborative agreements – formal or informal – *"Sometimes hospital and community agency staff don't communicate with one another. Patients get discharged with no place to go or we have difficulty getting patients into hospital. The same problem can exist between community agencies. Some*

means of increasing cooperation between the various sections needs to be developed."

(Toronto)

Rural – *"In the rural area, it is necessary for the mental health worker to become involved in the social life of the community."*

(Sudbury)

"In rural areas we sometimes have to travel a long distance to see our clients. This takes time and costs more (staff time and travel expenses.) This needs to be considered in funding."

(Thunder Bay)

Community support system – *"The psychiatrically disabled are readmitted or choose to admit themselves to hospital due to the lack of support systems in the community."*

"Schizophrenics are congregated into little groups. We end up spending all of our time with people with mental health problems. It's nice to see someone finally break away."

(Toronto)

Primary prevention – *"Primary prevention is an essential part of our mental health care system but it needs to be well thought out and based on effective interventions for specific high risk groups. We also need more training in order to provide this service effectively."*

(Chatham)

Summary

At the present time the mental health system includes:

a) an increased range of community based services;

b) program consultants to increase co-ordination;

c) a knowledgeable network of mental health workers; and

d) a growing network of families and consumers.

The system does not currently provide:

a) equal access to mental health services for all residents of Ontario;

b) a sufficient range of services to ensure quality of life as well as quality of care, particularly for those experiencing serious or prolonged mental illness or disorders;

c) an adequate means for data collection;

d) an adequate means for evaluating service delivery;

e) a means for developing an adequate partnership between consumers, families, and service providers in the delivery of mental health services; and

f) a means for facilitating a commitment to community-based program development by provincial hospitals and other Schedule 1 facilities.

C. Resources

The number of adult community mental health programs has increased substantially over the last few years. Presentations to this Committee demonstrated the dedication of those working within the system to providing quality care to those suffering from mental illness.

These facts accepted, it is clear that the actualization of the plans detailed by many of the District Health Councils will require additional funds and better access to trained professionals.

Heseltine (1983:188-196) gave a description of human resources within the province of Ontario. He noted the uneven distribution of mental health workers, with more professionals being clustered in regions having large cities. Cleghorn (1982) noted a lack of psychiatrists in certain specialty areas (child, geriatric, forensic) as well as in provincial psychiatric hospitals. Due to changes in legislation, foreign graduates are no longer supplementing the locally trained medical work force.

In many regions of Ontario the bulk of mental health care is the responsibility of family physicians or public health nurses. These health workers usually do not have sufficient or readily available psychiatric back-up at their disposal.

These health care workers need ongoing contact with, and information on, local mental health services and issues related to crisis, housing, medication, rehabilitation and counselling of the mentally ill, in order to fulfill their role as case managers.

Consultation is an essential and important component of any community mental health care system. It is an intervention that can be applied at every level of the system and delivered by every professional working within it. Consultation is an effective and efficient way of delivering services. One example of a consultation model is a mental health worker conducting the consultation in the general practitioner's office or by phone.

Although medical personnel are an essential part of the mental health care system, other people such as teachers, police officers, volunteers and family members are also essential resources. Self-help groups such as Friends of Schizophrenics and Manic-Depressive Family Support Group provide guidance and support for family members. Consumer groups such as On Our Own, The Manic Depressive Association and Friends and Advocates are also able to provide advice and support to persons with mental illnesses.

Professionals, paraprofessionals, and lay people alike need education and training on the most up-to-date approaches to treatment and rehabilitation of the mentally ill. Currently in Ontario there is an uneven distribution or notable lack of programs that embrace a community-based philosophy. While there are a number of programs that offer training in medical and psychotherapeutic treatment methods, none currently provides sufficient training in primary prevention or rehabilitation. Many of the needed programs would be valuable to many professionals. The programs that do exist are all located in the southern part of Ontario.

The Committee heard the following regarding resources during community consultations:

> **The psychiatrist's role:** incentives/disincentives in the OHIP Schedule - *"We lack psychiatrists in our area, particularly psychiatrists who have a community mental health orientation and knowledge of the severely mentally ill."*
>
> *"It isn't that we don't have enough psychiatrists in the province. It is that many psychiatrists trained in our universities seem to be attracted to large cities and to doing psychotherapy with healthy populations. Further, our OHIP billing schedule seems to encourage physicians into this type of work and discourages them from providing services to the severely mentally ill. It is a strange society that funds services such as psychoanalysis (delivered predominantly to healthy populations) but continues to underfund services for the severely mentally ill."*
>
> (Sudbury, Cornwall, Toronto)

Retention of staff – *"We have a hard time retaining mental health workers in rural and northern regions. This is particularly true if they have to go away in order to receive training. They tend not to return."*

(North Bay)

Staff with culturally relative backgrounds – *"We need service providers who are sensitive to the needs of certain ethnic groups."*

(Toronto)

Ongoing education – *"We need to provide training for our staff in our own community."*

(Sudbury)

Core curriculum for health sciences – *"Training about community mental health, the severely mentally ill and rehabilitation is needed at the basic health science level."*

(Guelph)

Role of the family physician – *"The role of the family physician is crucial to the provision of care for the mentally ill. They frequently do not get the psychiatric back-up they need."*

(Sudbury)

Consultant role, OHIP schedule – *"Psychiatrists need to be available for consultation with other health care professionals for diagnostic and medication related issues and receive appropriate compensation."*

(Oshawa)

Funding – *"Although funding to community mental health programs has increased significantly in the last year, it is still insufficient to provide an equitable and comprehensive community mental health care system for Ontario."*

(Oshawa)

General hospital budgets – *"A number of hospital based psychiatric services have lost funds to other medical services within the global budget of general hospitals."*

Lack of psychiatrists - rural – *"There are family practitioners available in most areas of Victoria County ... none, that I am aware of has any extra*

training in psychiatry... the only psychiatrist ... moved here in 1987 ... now seems to be working 40–50 hours a week in her retirement."

Summary

At present, the strength of our resources are:

a) the recent increased financial commitment to community mental health programs;

b) the willingness of family physicians to participate in mental health care;

c) the dedication of mental health workers currently working in the system; and

d) the recent commitment to a community–based philosophy by the Ministry of Health.

The current system does not provide:

a) a mechanism for the allocation and reallocation of resources to match a communityfocused philosophy;

b) sufficient education for health professionals on community–focused approaches to mental health care delivery; and

c) a sufficient number of mental health professionals in rural areas.

SECTION II

A PLAN FOR COMPREHENSIVE MENTAL HEALTH SERVICES IN ONTARIO

Introduction

The mentally ill are cared for by a variety of service providers and may, over the course of their treatment and recovery, be involved with several systems including health, education, criminal justice, social services, etc. The major focus brought to this work is a commitment to the belief that individuals with serious or prolonged mental illness are entitled to the services and supports they need to live as productive and satisfying lives as possible in the community.

The seriously mentally ill population is a diverse one in terms of its needs, concerns, strengths, motivations and disabilities. An effective service system, therefore, needs to be flexible and personalized.

Consumer and family rights, wishes and needs are paramount to planning and operating the mental health system. These people should therefore be involved, individually, at the treatment level and, collectively, at the systems level.

The community is the best source of care for most people. While in-patient facilities are part of community-focused services, they should be used only as a last resort for acute care and periods of stabilization, and for the small number of people in need of long-term in-patient care.

Local communities are the most knowledgeable when it comes to identifying their own needs, strengths, opportunities and gaps in service. They should, therefore, be responsible for planning and operating their own service programs.

Target Population

A. The Population Defined

"There are three commonly accepted dimensions currently being used to identify people with serious mental illness. They are diagnosis, disability, and duration. The diagnoses which predominate are schizophrenia, major affective disorders, organic brain syndrome, and paranoid and other psychoses. Disability refers to the fact that

the disorder interferes with the person's capacity to function normally, while duration refers to its chronic nature." (Canadian Mental Health Association, 1984)

B. Population Needs

In order to plan for and provide a suitable range of services, it is necessary to understand and describe the general needs of the mentally ill. Local planning should, therefore, begin with a description, in quantitative terms, of these specific needs within geographic areas. These figures, when combined with information about existing resources, will guide the planning process and the setting of goals and objectives.

C. Overall (General) Needs

Some people with mental illness are able to live fairly independently in their own communities; others experience enormous difficulties for long periods of time. People with serious mental illness do not form a homogeneous group. Their individual differences depend on each person's strengths and needs. Due to the nature of a mental disability, incapacity in some areas of living, or in all, may be acute and episodic or chronic and continuous. Access to a range of responsive mental health services is, therefore, essential.

Regardless of the methodology used, needs assessment is a complex process. It is often difficult to determine the needs of individuals living in the community given the large numbers who never make contact with the formal mental health system. Estimates of need are usually based on the actual number of people currently demanding or receiving services and do not take into account the larger unserved portion of the population.

Components of a Comprehensive Mental Health System

Introduction

A mental health system must offer input and support in certain areas and should be organized so as to successfully deliver services to clients. A two dimensional system is required to meet these goals. One dimension focuses on planning and coordination; the other on the provision of direct service and support.

It is difficult to design a single set of service components to fit all areas of the province. A large city like Toronto, for example, might be able to support housing programs ranging from high support group homes to independent apartments. To suggest a similar strategy for a small northern town or rural area would be impractical. The development of a whole range of programs is simply not warranted when only a handful of clients need the service.

The dilemma can be solved by shifting the focus from the kinds of programs required to the kinds of support functions a person is likely to need. This approach emphasizes the common needs of clients no matter where they live. To return to the housing example cited above, we can see that individuals, whether in a small town or a large city, have a common functional need. This need is not for a group home or apartment per se: the common need is for supportive residential living. While a group home may be one way in which to provide this, it is not the only way. In areas that cannot support a full-scale group home, other options can and should be used. If a client in such a community can secure an apartment, for example, regular visits from a case manager and homemaker can transform it into a supportive living situation. This focus on functions, and the idea that communities can devise different strategies to provide them, is called functional equivalence. It is a critical concept, especially when designing support models for small and/or remote communities.

In the following section the essential support functions required for a community-based mental health system are outlined. In each case, the function is described and followed by a brief discussion of the key issues related to a multiyear mental health service plan. As stated in the previous section, each multiyear plan must assess all of the key components, and outline concrete strategies for operationalizing each component.

Essential Functions in a Mental Health System

Identification

Treatment and crisis support Consultation Coordination Residential support Case coordination and case management Social support Vocational support Self-help/peer support Family support Advocacy

* **Identification**

An effective mental health system must identify and engage the mentally ill. The effects of serious mental illness can contribute to, and be

exacerbated by, an isolated lifestyle. Individuals may become shut-ins, homeless or in other ways lose the kinds of contacts that can lead to appropriate treatment and support. Outreach services include the provision of information regarding available programs, referrals to appropriate agencies, assistance with transportation, and providing treatment in an individual's own home, social environment or workplace.

Identification and outreach capacities need to be flexible and mobile enough to occur in settings such as soup kitchens, shelters and drop-in centres, and on the streets or in a person's home.

Issues for the Mental Health Service Plan: Multiyear plans should identify and describe current methods of identifying and reaching out to those in need. In many communities this happens in a variety of ways. Family physicians, general practitioners, public health nurses and hostel workers (in addition to families, neighbours and friends) are all likely to become aware of those in need of intervention. The plan should assess the current situation and describe strategies to both enhance existing approaches and develop new ones if needed. These strategies could range from providing educational and consultative support for general practitioners and other front line staff (to enhance their awareness of available services and to improve their coordination with each other) to developing models for new services to fill existing gaps. The principle of functional equivalence suggests that all multiyear plans should address identification and outreach needs. The ways in which they do so should be local and unique.

* **Treatment and Crisis Support**

These services should provide diagnostic evaluation, supportive counselling and psychotherapy, medication management and crisis assistance.

An effective system should be able to actively intervene in an outreach-oriented way in a variety of situations. Services should include individual support, 24-hour access to telephone or walk-in emergency services, mobile outreach, community crisis shelters and in-patient beds. Those called upon to intervene, be they mental health workers, police officers, general practitioners or members of the clergy, should receive assistance and education to deal with psychiatric emergencies.

Issues for the Mental Health Service Plan: Multiyear plans should include strategies outlining how diagnostic evaluation, supportive counselling and psychotherapy, medication management and crisis assistance will be

delivered. To begin with, an analysis of current services, including the identification of gaps in service and a clarification of the role of the local general hospital, should be undertaken. While service gaps are likely to vary widely across the province, in most areas they will depend on two key factors:

1. access to appropriate professional staff; and
2. the organization of staff to provide the range of services listed above.

In rural and remote areas, for example, access may be a key issue. On one hand, there may simply not be enough trained staff to meet the need; on the other, many people may have difficulty actually getting to the staff available. Multiyear plans in these areas will likely focus on attracting professionals and increasing their mobility.

In urban areas a different set of issues may arise. In Metropolitan Toronto, for example, there is a high ratio of professionals per capita: access is not usually a problem. The organization of these resources is, however, an issue.

The two key factors regarding access to, and the organization of, a full range of professional resources raises several other issues which multiyear plans may wish to address. These include:

- **Coordination** – A wide variety of professionals and non-professionals are involved in treatment and crisis support. It is essential that they work effectively together; and
- **Training and on-going education** – A supply of well-trained professionals who are ready and willing to work with the seriously mentally ill is essential. These professionals need ongoing training and support to function effectively.

The principle of functional equivalence is also relevant to treatment and crisis support. Rural or remote areas, for example, may be unable to support specialized crisis services. They do, however, often possess strong natural support networks. These networks are subject to intervention and enhancement, and are capable, with appropriate help, of improving their abilities to provide crisis support.

As with other component areas, the multiyear plan should be set within the context of all social and health agencies that provide treatment and crisis support, including public health and police departments, general hospitals, etc.

* **Consultation**

Consultation is an important and essential important component of any mental health care system. It is an intervention that can be applied at every level of the system and by every professional group working within it. Consultation can provide an effective and efficient way of utilizing more expensive, highly-trained or unavailable human resources to improve all aspects of service provision, for example, the isolation experienced by frontline mental health workers. There are a number of different ways of approaching a consultation:

Style	a)	direct (client seen) or indirect (client not seen);
	b)	case centred, problem centred or therapist centred;
	c)	agency centred.
Frequency	a)	regular (weekly/bi-weekly etc.);
	b)	intermittent (less than monthly); and
	c)	intensive (the consultant visits the program or community once or twice a year for a few days of concentrated activity).

Issues for the Mental Health Service Plan: Since consultation is traditionally regarded in the context of physicians' services, multiyear plans should begin with an analysis of the current local arrangements for sessional fees paid to psychiatrists for consultation to community mental health programs. From this, expenditures currently taking place can be estimated and recommendations made concerning availability of sessional fees throughout the local system. Local plans should also go beyond traditional consultation arrangements to explore its functional equivalence. In rural or remote areas, for example, various specialized services such as occupational therapy or medication management may be scarce. Consultation on a regular basis to frontline workers could be provided from other parts of the province where these services are well developed.

Consultation relationships should, wherever possible, be expanded to have a liaison component. This would mean that psychiatrists could be available to provide telephone advice or back-up outside of their consultation hours; be prepared to facilitate hospital admissions or advocate on behalf of programs and clients.

Psychiatrists and allied health workers should become more involved in non-hospital based mental health programs. Not only would this eventually

improve the range of clinical alternatives available, but it could bridge the gap between hospital-sponsored and community-sponsored programs.

* **Coordination**

To complement and reinforce the coordination of services and to develop an effective mental health system, services and resources must be well coordinated at both a local and provincial level.

The local mental health system is comprised of consumers, families, community agencies, hospitals, family physicians and other private practitioners. Coordination of their efforts is required to facilitate the most productive utilization of resources and the establishment of strong links between different services.

There are also a number of common functions that cut across the mandate or scope of any individual service, practitioner or institution. They are essential to the running of the system as a whole and often require collaboration between local representatives of different Ministries.

These functions are:

a) planning;
b) establishing funding priorities;
c) evaluation;
d) developing collaborative programs;
e) providing information on available services;
f) setting up a common entry point into the system; and
g) educating staff and trainees.

Communities may need to allocate funds specifically for the purposes of coordination to ensure that these activities take place.

To facilitate the development of a long-term plan, it will also be necessary to clearly state the respective roles and responsibilities of the various components of the system. How these components are to be linked and integrated with the system as a whole would also be defined.

At a provincial level, inter-ministerial collaboration and coordination is vital to ensure that the various components of care are available and to support collaborative initiatives at the local level.

Issues for the Mental Health Service Plan: Local communities will have to decide on the type of coordinating body needed and on the extent of its authority over local services, whatever their funding source. The question of local accountability is a complex one. Communities need to ensure that there is a mechanism in place to oversee the implementation and evaluation of their plans and cope with agencies or institutions whose plans are not consistent with the local direction.

The membership of these coordinating bodies should be carefully considered to ensure maximum participation of all relevant parties. Some communities may choose to establish more than one body with different memberships and purposes rather than delegating the responsibility for all coordinating and planning functions to one group.

The coordination of services and programs is essential to strengthening local systems. This can be reinforced if more than one agency or institution is involved in developing proposals for new services or programs. Local systems may also want to encourage informal contacts between services to address shared concerns, resolve common problems or inter-agency conflicts and to improve personal contacts and knowledge of other services.

* **Residential Support**

The seriously mentally ill often require support to find and maintain suitable housing. This can come about through specialized housing units and programs, or with the help of staff support to enhance an individual's current residential option. Large centres may develop a range of groups homes, cooperative apartments and boarding homes. Smaller communities may not have the resources to secure specialized housing units, but can provide staff support in regular facilities. Many people with serious mental illnesses in Ontario live in board and care homes. These facilities should be monitored by external agencies or Ministry of Health staff to protect individual rights.

Issues for the Mental Health Service Plan: Again, review of the current situations in all individual jurisdictions to identify gaps in service will be necessary. Housing problems can range from homelessness to the lack of appropriate models to meet individual needs. Issues can centre around the availability of housing stock itself, or the ways in which individuals are supported in available units (Ontario Housing Corporation, for example).

The mental health service plan should address both the availability of stock and the provision of appropriate levels and types of support. In the case of

availability, the key issue is making stock accessible to those in need. Some communities have responded by using foster homes or home sharing models in which homeowners make space available in exchange for payment and back-up support. This kind of model may be appropriate in small or remote areas that cannot support more formal programs such as group homes. A functionally equivalent approach in a large urban area might be to construct new units earmarked for individuals who have had psychiatric treatment. This approach requires the involvement of several Ministries and municipal officials in the planning process.

The provision of appropriate support in residential situations is the second area to be addressed in the plan. Questions to be examined include:

- What range, if any, of housing options currently exists?
- Is there a flexible range of support available to help people live in the community? For example, are homemaking services available to those who want to live independently in an apartment, or do they have to move in to a group home to get help?
- Are special initiatives needed, for example, for the homeless?

* **Case Coordination and Case Management**

Using mental health professionals to coordinate services received by an individual is an important way to ensure that client needs are met in an effective and efficient manner. This applies whether services are offered for a short period of time or over many years.

Seven basic functions of service coordination have been identified:

- assessing client needs;
- developing comprehensive service or treatment plans;
- ensuring services are delivered;
- advocating on the client's behalf;
- providing information and support, and facilitating the utilization of services whenever necessary;
- monitoring and assessing the impact of services delivered; and
- re-evaluating client needs and treatment plans regularly.

Case coordination can be provided by any mental health professional. The more complex the system of services, the more important it becomes. More specialized forms of coordination include services offered through a psychosocial clubhouse and case management.

Case management implies a longer term relationship with a client with an emphasis on rehabilitation and community re-integration. In most communities, case management is an essential service for selected patients and should be targeted at those who are most likely to benefit from it rather than something to be offered to every person with a significant psychiatric disability.

A great deal of debate has taken place recently about the distinction between advocacy and case management. A recent provincial review of advocacy in Ontario, You've Got a Friend: The Review of Advocacy for Vulnerable Adults (1987), concluded that an important distinction exists: " ... while case management often includes advocacy as a component, true advocacy does not include a case management function."

Issues for the Mental Health Service Plan: Multiyear plans should estimate needs and accurately describe the present and proposed future service system that will be in place by 1995. As well, resources, such as income support, to be accessed by the seriously mentally ill outside of the jurisdiction of the Ministry of Health should be identified as key elements of the plan. Once all prescribed elements are identified, local planners can then identify the timing to eliminate service gaps and priorize the development of essential services. In many underserved areas of the province, case management or the coordination of services may not be the first services required due to an inadequate array of services. In rural and remote areas, for example, some of the basic functions of case coordination such as providing information and support may be quite useful in the early development of a comprehensive service system.

* **Social Support**

Social support and rehabilitation is critical for community life. Issues to be considered include social skills teaching, use of leisure time, orientation to community facilities and resources, social network enhancement and organized social activities.

Social support is currently provided by a variety of groups ranging from strictly recreational services to sophisticated rehabilitation

interventions. *"Providers of such services include: church groups, community centres, social service agencies, community mental health organizations, municipal recreation services, voluntary organizations and general and provincial hospital psychiatry facilities. Funding comes from a wide range of sources including the Ministries of Health, Community and Social Services, charitable institutions, private donations, and municipal governments"* (Community Resources Consultants of Toronto).

There are many models available to carry out these functions, and appropriate choices should be made on a local and client basis.

Issues for the Mental Health Service Plan: Multiyear plans should identify and describe current social supports and rehabilitation services in order to assess their supportive capacity and accessibility for the seriously mentally ill. Many services exist in all parts of the province, yet most are not oriented toward this population. The plan might include strategies for providing education and support to existing services or for the development of population specific services that stress self-help and mutual support concepts. Again the principle of functional equivalence should permit the development of various innovative models of social support services throughout the province.

* **Vocational Support**

Employment not only provides valued economic rewards but can also contribute to a person's self-worth. Work provides opportunities for socialization and a sense of belonging. The seriously mentally ill require a range of vocational services and employment options, for example:

- assessment;
- work adjustment;
- skill training and education;
- supported employment;
- sheltered employment;
- transitional employment; and
- job placement.

Programs should be structured to enhance the participation of clients in both the development and operation of vocational programs. The goal is to provide opportunities for meaningful and productive activity that is individually appropriate. The actual outcome of vocational support services may be full-time, part-time, intermittent or voluntary work. Often, the nature of a serious mental illness is such that supported employment, as opposed to regular competitive employment, will be the most successful.

Issues for the Mental Health Service Plan: Multiyear plans should first review the existing services offered by various providers and levels of government. Consultation from consumers, agencies and employers is crucial to identifying the variety of vocational supports needed, gaps and weaknesses in services, and the ability of the job market to respond to defined needs. Coordination with income support programs is also necessary to allow for the maximization of income and the retention of other necessary benefits. Collaboration will be needed by the provincial Ministries involved in order to develop necessary services.

There may be an adequate supply of employment opportunities for people with serious mental illness in urban areas. Specific and necessary supports, including appropriate accommodation may, however, be missing. In underserved areas where work opportunities and transportation are lacking, a different strategy will be needed. One alternative may be to develop a business whose aim is to provide vocational opportunities for the mentally ill. Another might be work done in the home. Transportation alternatives should also be investigated.

* **Self-Help/Peer Support**

Each community or local mental health plan should have consumer and self-help groups as part of the range of support options. These groups should be consumer-controlled and focus on peoples' needs for friendship and a sense of community. They may be large and formally funded, or small and informal. In some cases, self-help groups may take on other support functions such as the provision of social or vocational support.

Issues for the Mental Health Service Plan: Multiyear plans should identify and describe existing self-help groups for the target population. Contact with these groups can be the first step toward assessing the needs of the larger population. When services or programs are being developed, self-help and peer support should be considered a necessary ingredient of successful mental health system.

Numerous self-help groups exist throughout the province. In areas where few exist, information from groups in other communities can be obtained through local professionals, provincially-based organizations, church groups, the Ministry of Health, etc. In many cases self-help groups may not need a great deal of funding to begin with, but will need other resources, for example, meeting space, help in reaching prospective members and leadership development.

* **Family Support**

Large numbers of seriously mentally ill people live with their families. Support for these families is essential to maintaining and enhancing their role as caregivers. This type of support may include counselling, education, respite care, crisis intervention and peer support groups, to name a few. Whenever possible, families should be included in the development of treatment and aftercare plans as well as in the planning and development of local mental health services.

Issues for the Mental Health Service Plan: Multiyear plans should include strategies to involve families of the seriously mentally ill in the planning, development and operation of services. As essential caregivers, specific services to support and enhance their role must be developed.

In rural and remote areas many essential service functions may be underdeveloped. In planning a full range of services, keeping in mind functional equivalence, some services may be developed to achieve more than one function. A mobile treatment and crisis support service designed to serve clients in the home could also have a built-in family support component.

In some urban areas where in-patient bed utilization is greater, family support groups have developed into important components of treatment and aftercare. A serious mental illness can create confusion and often a sense of helplessness for the entire family. A responsive mental health system acknowledges the needs of all family members for accurate information, timely assistance and ongoing support.

* **Advocacy**

Advocacy should be an integral part of mental health services. Clients have the right to be informed of their legal rights, entitlements and available resources. The objectives of advocacy presented in the O'Sullivan Review, You've Got a Friend: The Review of Advocacy for Vulnerable Adults (1987), are:

> " * *to promote respect for the rights, freedoms and dignity of the persons ... éadvocatesù serve, both individually and collectively;*
>
> * *to ensure that their clients' legal and human rights are recognized and protected;*
>
> * *to assist their clients to receive the health care and social services to which they are entitled and which they wish to receive;*

- *to enhance the autonomy of their clients by advocating on their behalf, both individually and collectively;*
- *to assist their clients to lead lives that are as independent as possible, and in the least restrictive environment possible;*
- *to help protect ... disadvantaged persons from financial, physical and psychological abuse;*
- *to fully explain the implications of and provide advice with respect to guardianship and conservatorship under the Substitute Decisions Authority Act (or the current legislation it is intended to replace)."*

Issues for the Mental Health Service Plan: In Ontario, advocacy services have recently attracted a great deal of attention and been the subject of much debate. Both You've Got a Friend and The Attorney General's Advisory Committee on Substitute Decision Making for Mentally Incapacitated Persons have dealt in depth with the question of advocacy in the community. As well, the recent evaluation of the Psychiatric Patient Advocate Office has made several recommendations to extend advocacy services beyond institutions into the community.

Local plans should take direction from these reports in order to adequately address province-wide developments in advocacy services. At present, few advocacy services exist in the community. That is not to say that advocacy does not exist. Advocacy is undertaken by a wide variety of service providers, volunteers, clients, families and friends at the client, local and provincial levels. Nonetheless, a serious mental illness can leave an individual open to abuse, neglect, and abandonment. Understanding and obtaining services and entitlements can be a very complicated process and may, at times, require the services of someone to speak on the client's behalf. In underserved areas, advocacy services may focus initially on the development of needed services and be provided by a coalition of concerned individuals. Again, the concept of functional equivalence should be used in multiyear plans to accurately describe the role of local advocates.

A. Principles

Mental health services provided by community agencies, general hospitals, psychiatric hospitals and other professionals should reflect the following principles in order to qualify for funding:

- **Focused in the community:** Care is provided in such a way so as to enable individuals to obtain needed support and encourage them

to make use of family, friends, and other naturally occurring helping relationships. A broad cross-section of the community including consumers and their families, should have direct input into the planning, development, ongoing operation and evaluation of services;

- **Mandated:** Communities and government share the responsibility to ensure that a full range of services is provided;
- **Comprehensive:** A range of services will be available to meet diverse needs and provide for consumer choice about how needs are met;
- **Individualized:** Care is particular and appropriate, planned with and for the individual and his family and directed toward enhancing individual participation in community life;
- **Flexible:** Services should be adaptable and responsive to the special needs of identified individuals, groups and communities, and to changing needs over time;
- **Accessible:** Services should be provided in such a way so as to ensure that they are available to those most in need and that individuals will not experience significant difficulties in using them;
- **Coordinated:** The service system must provide for the continuity of care and ensure that integration takes place at the client, program and system levels;
- **Accountable:** Supports and services should be monitored, evaluated and adjusted in order to remain appropriate and responsive to changing client needs. Consumers, family members, as well as service providers, are involved in the development, operation and evaluation of services;
- **Culturally and geographically relevant:** The dimensions of a service system must reflect the unique characteristics of specific communities and target populations within them;
- **Functionally equivalent:** Services are developed with the recognition that a variety of service interventions can meet the same need;
- **Use of natural and informal supports:** Self help approaches and natural support systems (that is, family, friends, community) are essential to the maintenance of mental health and to the treatment of mental illness; and

- **Effective:** The mental health plan will encompass more than the narrow range of traditional services. Services will be evaluated in relation to their effects on quality of life as well as outcome measures.

B. Goals for a Comprehensive Mental Health System

Ontario should develop a mental health care system to deliver comprehensive services that:

i) ensure all residents of Ontario access to mental health services in, or as close to, their own communities as possible;

ii) place priority on providing support to individuals and their families who experience serious or prolonged mental illness or impairment;

iii) recognize the multi-dimensional nature of the origin and management of mental illness;

iv) ensure a balance between institutional and community sectors of the mental health system by providing an adequate supply of a range of formal and informal supports and treatment in order to reduce the need for institutionalization, in response to geographic and population needs;

v) enhance quality of life as well as quality of care by maintaining people in the community and close to their natural environments; and

vi) provide access to adequate incomes through work or social assistance.

The mental health system provides for:

i) a partnership between consumers, their families, service providers and government in the planning, development and delivery of services;

ii) improved communication and cooperation between Ministries and other levels of government;

iii) a balance between province-wide perspectives and local priorities that encourages flexibility and community innovation; and

iv) the integration of services provided by health professionals, community agencies, general hospitals and provincial psychiatric hospitals.

Planning

Introduction

The overall purpose of this report is to enable the provincial government, through the Community Mental Health Branch, to convey a long range plan for the development and implementation of an organized, comprehensive mental health care system to the people of Ontario.

The components discussed earlier provide the framework for a wide range of community focused mental health services. The development of effective services is predicated on making a support system available in each community. The system requires commitment and resources, including the designation of an individual, agency, or entity with responsibility for program planning, development, coordination, monitoring and evaluation at the provincial and local levels. This responsibility could be assigned to the District Health Councils or their equivalent.

It should be noted that a number of people with serious mental illness also have other types of disabilities and/or unique service needs: the hearing impaired, for instance, or the physically or developmentally handicapped. Others with unique service needs include women, minorities, the homeless, senior citizens, youth, alcohol and drug abusers. It is the Committee's belief that planning should focus on people and their problems. Specific target groups should be identified and ranked in order of priority before programs and services are designated for funding. The geographic variability of some populations emphasizes the importance of local planning based on a thorough knowledge of the community's population.

As well, there are a significant number of groups who, despite the severity of their members' needs, do not use the mental health system or, having used the system, do not follow through with support programs. In many of these cases mental health services are not relevant or appropriate to their unique needs. More targeted outreach services should, therefore, be considered by both planners and service providers.

Service plans should be designed to ensure that each individual receives appropriate services and that particular populations do not consistently receive a predetermined set of services regardless of their unique needs. As stated before, it is incumbent upon the mental health system to adapt its services to meet the needs of special populations.

The components described above reflect needed changes in the delivery of mental health care. The changes are needed in order to continue to serve people with serious mental illness in an effective manner and to develop at least a minimal level of services for people who, historically, have been underserved.

In recent years a number of jurisdictions have passed legislation aimed at guaranteeing entitlements for community mental health services. The American Congress recently passed legislation that will enable states to develop plans for the provision of services to the severely mentally ill. The legislation also calls for mechanisms for the reporting of outcomes in relation to service plans in order to qualify for federal funding.

A number of states have similarly passed legislation identifying service entitlements for people with severe mental illnesses. An integral part of such legislation is a definition of service components and principles of service delivery to guide state planning.

In Canada, a number of groups and reports have identified principles and components of a service delivery system for the severely mentally ill. Legislation based on this material was tabled in the Ontario legislature recently.

Legislation today tends to be written in terms of broad principles. Regulations are then developed to implement the legislation. These regulations can be used to establish standards and to drive funding decisions: they can also be used to limit them.

Adequate funding is critical to the success of any legislation setting out service entitlements. Where funds have not been voted in, legislation has been considered a failure in terms of achieving system objectives. However, Ontario's experience indicates that legislation can be used to enunciate service principles and consumer rights and to facilitate the planning process as long as the political will to provide adequate funding exists.

A. Local Plans

Multiyear plans

> *"The planning cycle for community mental health, based on year-to-year funding and calls for funding applications has led to a fragmented approach to planning."* (Canadian Mental Health Association. Ottawa-Carleton Branch)

This comment from one submission we received summarizes local planning frustration. In order to resolve this dilemma several changes to current funding and planning approaches will be needed.

Local planning bodies such as District Health Councils (or designates) should, therefore, develop or revise their local community mental health plans to embody the goals and principles outlined and to provide for the various components of service described.

In this way, planning will be expanded to a local and community-wide process resulting in a multiyear plan. Given the comprehensive nature of the essential components, it may, in some cases, take up to 10 years to actually implement the service components in some communities. As well, the development of local plans will take time and resources. The process can, however, be initiated immediately based on current studies. Plans and resources should be in place by 1991.

One of the critical issues in developing a multiyear plan for the provision of local services is the ability to actually demonstrate, in concrete terms, the development of linkages between hospitals and community services. The first step toward this is to involve key players from both the hospital and community sectors in planning.

> *"In our case, the lines between the two are not clear, and there is good potential for the two sectors to become increasingly integrated ... when local circumstances suggest that it is in the best interests of the community."*
> (Wellington-Dufferin District Health Council)

The hospital sector includes the provincial psychiatric hospitals and psychiatric units of general hospitals. Community services involved in the mental health field are numerous and cut across many jurisdictions. The people involved in local planning should represent all essential service components. This type of partnership planning should also apply to actual service delivery. Service agreements between sectors should be encouraged and may range from voluntary agreements all the way to formal contracts between service providers and endorsed by provincial legislation.

The mental health planning process must also reflect the full participation of consumers and family members.

> *"The views of people who have experienced the mental health system raise important contradictions about the system itself and the volunteers and professionals whose efforts are supposed to help ... The issue facing volunteers*

and professionals is how to move beyond the label (the disability) and see and hear the person as a valued human being. Neither of these dilemmas are easily resolved, but listening and understanding is an important first step."
(Canadian Mental Health Association, Listening, 1985)

It may not be enough to simply have consumer representation on local boards and District Health Council mental health sub-committees. Greater efforts should be made to solicit the views and ideas of consumers and family members. Throughout the planning, developmental and operational stages, these views can be actively sought through a variety of mechanisms: advisory groups, public hearings/meetings, individualized questionnaires and the direct participation of clients and families served by the programs. Of special concern is the direct participation of consumers on planning bodies and other local services. In many cases, training and financial resources will have to be developed to fully accommodate this kind of representation. Service plans must reflect more than consumer representation. The views of all key stakeholders in community mental health should be actively sought out in the planning process.

In order to be useful and realistic, a multiyear plan must have a mechanism to assess community needs, shift resources and change the type of services offered. This is necessary to ensure that the service system is dynamic and adjusted as required to meet the goals of the plan. The actual mechanism used may vary across the province. It may be inherent in the overall plan or it may be a specific function taken on by the District Health Councils or other planning bodies, or it may be a new development such as a local authority. An example is the present structure of the Grey-Bruce Health Corporation.

Throughout the province, psychiatric hospital catchment areas tend to cross over, as do other types of broad-based services, more than one District Health Council jurisdiction. Given the fact that local multiyear plans involve both psychiatric and general hospitals, issues may arise that can only be resolved at a higher level. One solution would be to establish Area Mental Health Advisory Boards in each of the six Ministry of Health area planning regions. Membership of these boards should include representatives from each local council. Advisory boards may also be well suited to developing and monitoring information systems on target populations, resource utilization and service inventories.

The determinants of assessment of need and adjustment of the plan should be based on utilization and other outcome data. This will mean more rigorous approaches to service design and evaluation. This will also require additional

resources and the development of new tools and techniques that are useful and efficient at the community level.

Regardless of where the responsibility lies, it is essential that annual reports be prepared to review progress made toward the plan's objectives and recommendations for new funding initiatives in relation to the multiyear plan.

Evaluation should be an integral component of every program and service. The purposes of evaluation can be different, however, and may include:

1. To examine whether a program is meeting its objectives and/or maintaining acceptable service standards;
2. To test whether a particular intervention is effective and/or efficient;
3. To conduct research or a scientific appraisal of certain types of interventions; and
4. To determine whether a program or service is continuing to fulfill its role/commitments within the overall community service plan.

To date, only programs funded through Community Mental Health Branch have been subject to evaluation. It is important to ensure that services provided by general and provincial psychiatric hospitals, as well as by the Community Mental Health Branch are evaluated in terms of program objectives and standards of performance.

All new program funding proposals should include a stated plan for program evaluation. Where internal resources are not sufficient (financially or otherwise) to conduct a proper evaluation, the means to obtain suitable resources should be built into the plan.

The evaluation of funded programs that are past the developmental phase should be conducted regularly to determine whether the program is still directing its resources in a manner that is consistent with stated objectives, and whether these objectives are still relevant to the community's needs. Where programs have deviated from agreed objectives, or where community needs have changed, a mechanism for re-orientation needs to be established.

Although it is unlikely that a program considered to be ideal in one community can be transplanted as is into another, it is important that effective

interventions be shared. The Ontario Federation of Community Mental Health and Addiction Programs is one way of obtaining this objective. Support for programs to get together locally should be explored. A list of available services (for example, work, family support, and prevention programs) would facilitate a consultative process. Information on effective interventions offered outside of the province should also be made available to these programs through the Ministry.

An important question becomes whether program evaluation should be conducted internally, as part of an ongoing developmental process, or by an external reviewer using independent criteria. Since the primary objective of evaluation is to provide feedback internally in order to enable each program to develop effectively, some combination of internal and external review process would be beneficial.

Systematic and effective evaluation has the effect of generating a solid body of data which should be made accessible for the purposes of applied research. To address current and future demands for data, a centralized depository or database will be needed to serve both institutional and community-based services.

B. Provincial Plans

Without a clearly defined approach to service delivery articulated at the provincial level, and consistently and clearly understood at the local planning level, the ability to coordinate and direct all sectors cannot be achieved. Only when this occurs, can a province-wide system of evaluation be implemented.

In-patient treatment in general and provincial psychiatric hospitals is an integral part of Ontario's mental health system. Each area of the province is served by one of ten provincial hospitals administered directly by the Ministry of Health. General hospital psychiatric units available in most urban centres provide specialized and regional services as defined in Schedule 1 of the Mental Health Act.

In general, there is a heavy demand for in-patient beds throughout the system. To relieve this pressure, most hospitals have developed out-patient programs. Some have been actively involved in developing a variety of community mental health services under their sponsorship. Nonetheless, the role of hospitals within the overall mental health service delivery system requires further examination, clarification and definition. The most critical issues in this regard are:

* **the direction of provincial psychiatric hospitals** – Should these institutions continue to be a direct service of the Ministry of Health or should they be operated as public hospitals under local regional control?

* **community alternatives** – How can hospital resources be reallocated to community programs in response to the needs of the patient population of the communities served by the hospital?

* **partnership** – How can hospitals and community mental health services forge service agreements that will ensure a continuum of community-based services is available to consumers and families?

* **information system** – What data should be collected from the total mental health system to answer questions regarding program planning and performance?

* **cost effectiveness** – What mechanisms can be used to measure the efficacy of hospital and community services to ensure that funds are being spent wisely?

While funding for community mental health services has increased over the years, the fact that total mental health spending has declined as a proportion of government spending, may create an impediment to the creation of a balanced mental health care system in Ontario. Community mental health program funding and institutional services targeted at persons experiencing serious or prolonged mental illness lost ground in relation to other areas of mental health spending. Expenditures on OHIP and alcohol and drug addiction programs were the only areas to increase their proportionate share of the mental health budget. Even so, their rate of increase fell well behind the overall increase in Ministry of Health spending in the period under review.

Between 1979/80 and 1987/88, Ministry of Health spending for health care has increased at almost three times the rate of the increase to spending on services for people with psychiatric disabilities and/or serious mental illness (162% compared with 61%). Attempts to restrain mental health spending further as part of a health care cost containment strategy could cause further delays in the development of a responsive, coordinated mental health delivery system in Ontario.

There are a variety of funding options that exist with regard to mental health services. These are summarized and assessed in relation to the likely impact on the development of an appropriately balanced mental health care system, one that focuses on community alternatives.

1. **Restrain spending growth.**

In this scenario, institutional and hospital spending would continue to decline. As well, growth in community mental health spending would likely be contained. Current problems with regard to distribution and availability of services would continue.

Expansion of community mental health services would be difficult without the reallocation of dollars spent on institutions. The reallocation of institutional dollars would be difficult to achieve without closing some facilities.

2. **Moderate increases in community mental health funding.**

This appears to be the strategy announced during the last provincial election campaign. Available funding would go toward enhancing existing community mental health programs and developing new services.

There would be movement toward the objective of a balanced mental health system but it is unlikely that the objective could be achieved in three years. It is doubtful that the spending increases contemplated would be sufficient to fill service gaps and shortages across the province without a longer term commitment of funds. Decisions with regard to increases in institutional spending would be required as well.

3. **Increase mental health funding as a proportion of Ministry of Health and government spending.**

This strategy would result in a significant increase in funding and resources for mental health. It would provide for a flexible approach to the enhancement of both institutional and community-based services. Allocation of funds could be targeted based on the definition of system components. Within the context of a long term plan it would be possible to allocate an increasing proportion of funds to communitybased mental health services.

There would be greater progress toward a balanced mental health care system, however, the achievement of this objective would require a plan and funding commitment for more than three years.

4. **Utilize funding from other systems.**

It is possible to augment Ministry of Health funding for community mental health services by the development of cost sharing strategies with

other provincial government Ministries and levels of government. Examples already exist: the Supportive Community Living Project with the Ministry of Housing has resulted in increased funding for supportive housing programs; Canada Assistance Plan funds are being used to partially fund existing vocational programs and it appears that there may be flexibility for increased cost sharing on housing and case management services. Habitat Services and the Contract Aftercare Program are examples of creative cost sharing between provincial Ministries and local government to upgrade boarding homes. Other opportunities are available, particularly with regard to vocational rehabilitation. It would also be possible to utilise HSO's and CHC's to fund primary care and related support services for consumers of mental health services.

The development of agreements between Ministries and other levels of government takes time to implement and often requires protracted negotiations. However, there is evidence in Ontario and other jurisdictions that this approach can work and result in the enhanced coordination of services, as well as an increased funding base for mental health services.

It should be noted that this strategy can be used to augment funding now available for mental health services but would not, by itself, lead to a balanced mental health care system.

The planning framework and principles proposed in this report are intended to guide the planning process necessary to develop and maintain mental health services in Ontario. Each plan should specify how services are to be organized in order to provide equal access to the range of service components identified.

Local communities should be encouraged to utilize the concept of functional equivalence (whereby a number of services achieve the same goal) in the development of service plans. It is important that local communities be allowed some flexibility in determining how they are going to provide identified components of support.

A number of strategies can be employed to encourage local communities to develop the range of services envisaged. These include:

a) Establishing local authorities to develop the plan, guide the funding process and monitor system performance. Local authorities can be given full funding authority or the authority to develop and monitor the service plan. They can be catchment area based, regionally or locally constituted.

b) Encouraging joint ventures between hospitals and community agencies that lead to the development of a more integrated mental health care system. For example, a hospital could provide psychiatric consultation and crisis services to a supportive housing program. Initiatives similar to this are currently planned in Kingston and Scarborough.

c) Using health service organizations (HSO's) and community health centres (CHC's) to provide community mental health services. These organizations could be used to provide primary care and medical therapeutic services to the mentally ill. Other community support services could be attached in a similar manner to health promotion activities sponsored by CHC's and HSO's.

d) Developing new approaches to funding community mental health services. Mental health services are now funded through fees, program funding or global budgets. Many jurisdictions are implementing approaches where money follows the client through the service system. A service brokerage model allocates a certain sum of money to a client to "purchase" required services. The client utilizes a service broker to develop an individualized service plan and access the services in his/her plan.

e) Encouraging rural and remote areas to develop and identify service models that will enable people living in non-urban areas to gain access to the range of services specified.

It is important to note the impact of anticipated internal and external environmental changes on the roles of the key players in the provincial mental health system. The philosophical thrust and major policy initiatives outlined in this plan enhance and expand the role of the community in providing comprehensive mental health services. While this trend is consistent with provincial trends over the past several years, the emphasis on community support systems, treatment of the whole person, and the shift in emphasis from a treatment oriented model to a treatment, support and rehabilitation orientation places a significantly greater burden on community mental health organizations.

An important element in the expansion of mental health services is the role of promotion and education activities. As local community services become more visible, for example, strategies to communicate accurate information to the general public are necessary. Because the emphasis in this report is on resources for new and enhanced services, a separate funding strategy should be developed by the Ministry of Health for mental health promotion and education activities.

Although the future development of mental health services rests, in no small part, with the community, the Community Mental Health Branch must provide

leadership, direction, planning, evaluation, standard setting, research, training and resources to support the development of a community system. The challenge for both the community and the provincial government involves change, strain on available resources and the need to provide local leadership to develop improved linkages with other health and human service providers. While local autonomy is a key part of this plan, communities must also recognize that they are part of a larger system. Not everyone will agree on the recommended changes and policies but everyone has some responsibility for the viability of the system as a whole.

The enhancement of community services will require new resources, more creative and efficient use of existing resources and an emphasis on different services. As changes are initiated over the next few years through province-wide planning, roles will also change and evolve.

The current compensation review for community mental health programs undertaken by the Ministry of Health in collaboration with the Ontario Federation of Community Mental Health and Addiction Programs should provide useful guidelines for the financial enhancement of staff positions. This will, hopefully, help agencies keep and attract qualified personnel in community-based services.

Although medical personnel form an integral part of the mental health care delivery system, many services are provided by other professionals including nurses, social workers and occupational therapists. While the professional sector is significant, there are other stakeholders who also play important roles. These include: paraprofessionals of various backgrounds, volunteers and family members. In some parts of the province, training and education for community mental health exists but is, for the most part, uncoordinated and inconsistent.

Given the need for specialized professional and non-professional education and training, it is recommended that one centre be identified as a province-wide training centre for mental health and psychiatry. A multi-disciplinary teaching, applied training and research centre should begin to address the varied human resource and research/evaluation needs of the province.

APPENDIX I

PROVINCIAL COMMUNITY MENTAL HEALTH COMMITTEE

AREA MEETINGS

December 4, 1987	**North West Area** Contact: Mr. Celso Teixeira Thunder Bay District Health Council Telephone: (807) 623–6131	**Thunder Bay**
December 11, 1987	**East Area** Contact: Mr. Donald St. Pierre District Health Council of Eastern Ontario Telephone: (613) 933–9585	**Cornwall**
December 18, 1987	**Central West Area** Contact: Mr. Rob Simpson Wellington–Dufferin District Health Council Telephone: (519) 884–6390	**Guelph**
January 11, 1988	**Central East Area** Contact: Ms. Evelyn Kent Metropolitan Toronto District Health Council Telephone: (416) 922–8820	**Metro Toronto**
January 15, 1988	**South West Area** Contact: Ms. Karen Levenick Grey Bruce District Health Council Telephone: (519) 376–6691	**Chatham**
January 22, 1988	**Central East Area** Contact: Mr. Floyd Dale County of Simcoe District Health Council Telephone: (705) 726–9300	**Oshawa**
January 29, 1988	**North East Area** Contact: Mr. Ken Hoffman Manitoulin–Sudbury District Health Council Telephone: (705) 675–5654	**Sudbury**

APPENDIX II

PROVINCIAL COMMUNITY MENTAL HEALTH COMMITTEE REPORT
WRITTEN SUBMISSIONS RECEIVED BY THE COMMITTEE,
DECEMBER 4, 1987 – JANUARY 29, 1988

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Dr. John A. Ward
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Division of Extended Campus Programmes
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ACFO
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Submitted by Mr. Alcide Gour

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Submitted by Ms. Margaret Dobie

Alpha Court
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Submitted by Ms. Fleurette LeClair

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Submitted by Mr. A.E. (Gus) Ashawasega

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Atikokan General Hospital
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The Canadian Hearing Society, Head Office
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The Canadian Hearing Society
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Submitted by Ms. Cathy Cuthbertson

The Canadian Hearing Society
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Canadian Mental Health Association
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Submitted by Ms. Barbara MacKinnon

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Submitted by Sister Leila Greco

Canadian Mental Health Association
Sault Ste. Marie Branch
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Submitted by Ms. Mary Ann Quinlan &
Ms. Susan Capstick

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Mr. Maurice Fortin &
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Mr. Grant Lowery

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Submitted by Mr. Mel Gill

Children's Services Council (Windsor–Essex)
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Submitted by Ms. Helene Gordon

Chinese Canadian National Council
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Submitted by Mr. Gary Yee

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Submitted by Ms. Betty Lyn Enns

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Corporation of the County of Kent
P.O. Box 1230
Chatham, Ontario
N7M 5L8
Submitted by Ms. M.E. Kuchta

Community Mental Health Centre
Box 4000
Alliston, Ontario
L0M 1A0
Submitted by Ms. Mary Lou Moir &
Ms. Mary McGill

Community Resources Consultants of
Toronto
120 Eglinton Avenue East
Toronto, Ontario
M4P 1E2
Submitted by Mr. Ron Ballantyne

Community Resources Consultants of Toronto
120 Eglinton Avenue East
Toronto, Ontario
M4P 1E2

Coordinating & Advisory Council for Mental Health Services in York Region
47 Main Street
Newmarket, Ontario
L3Y 3Y3
Submitted by Dr. Robert Camargo &
Dr. William Laurie &
Dr. Melanie Telegdi &
Ms. Avril Davies &
Mr. Giorgio Ilacqua

Coordinating & Advisory Council for Mental Health Services in York Region
47 Main Street
Newmarket, Ontario
L3Y 3Y3
Submitted by Mr. James Simon

Coordinating & Advisory Council for Mental Health Services in York Region
47 Main Street
Newmarket, Ontario
L3Y 3Y3
Submitted by Dr. Alan M. Toomey &
Ms. Ann Mallory &
Ms. Charlotte Cameron &
Ms. Nana Rosenberger &
Dr. J.O. Slingerland

The Corporation of the City of Windsor
Social Services Department
755 Louis Avenue
Windsor, Ontario
N9A 1X3
Submitted by Ms. Dana Howe

County of Simcoe District Health Council
County Administration Centre
Midhurst, Ontario
L0L 1X0

The District Health Council of Eastern Ontario
P.O. Box 1478
Cornwall, Ontario
K6H 5V5

Durham Region District Health Council
40 King Street West Suite 300
Oshawa, Ontario
L1H 1A4
Submitted by Mr. Ron Shaw

Essex County District Health Council
76 University Avenue West
Windsor, Ontario
N9A 5N7

Etobicoke Mental Health Services Agency
19 Glen Agar Drive
Islington, Ontario
M9B 5L5
Submitted by Ms. Marlene Swarbrick

Family Focus – Leeds & Grenville
P.O. Box 721
Brockville, Ontario
K6V 5V8
Submitted by Ms. Janice Giffin

Family Service Association of Metropolitan Toronto
22 Wellesley Street East
Toronto, Ontario
M4Y 1G3
Submitted by Mr. Robert Couchman

Fort Frances Clinic Victoria at Nelson
Fort Frances, Ontario
P9A 2C1
Submitted by Dr. R. Moulton

Friends and Advocates Centre North York
34 Lescon Road, Room 202 Willowdale,
Ontario M2J 2G6
Submitted by Ms. Asta Dvorak

Friends of Schizophrenics Brampton Chapter
c/o Mr. Al Stokes
22 Erindale Crescent
Brampton, Ontario
L6W 1B5
Submitted by Ms. Diana Fishleigh

Friends of Schizophrenics Sarnia Chapter
1320 L. Chipican Drive
Sarnia, Ontario
N7V 3C1
Submitted by Ms. Helen Rankin

Grey–Bruce District Health Council
945 Third Avenue East
Owen Sound,
Ontario N4K 2K8

Grey Bruce Family Violence Prevention Committee
The Spouse Abuse Committee
c/o Community Network Support Team
1139 2nd Avenue East
Owen Sound, Ontario
N4K 2J1
Submitted by Ms. Donna Senese &
Ms. Colleen Purdon–Ostertag
& Mr. Steve Boechler

Grey Bruce Regional Health Centre
Mental Health Services Department
P.O. Box 1400
Owen Sound, Ontario
N4K 6M9
Submitted by Mr. Timothy L. Hill

Haldimand–Norfolk District Health Council
101 Nanticoke Creek Parkway
P.O. Box 5081
Townsend, Ontario
N0A 1S0
Submitted by Mr. Anthony J. Bailey

Haliburton, Kawartha & Pine Ridge District Health Council
P.O. Box 544
Peterborough, Ontario
K9J 6Z6
Submitted by Mr. Alan Worthington &
Ms. Maureen Dikun

Halton District Health Council
700 Dorval Drive
Oakville, Ontario
L6J 5A2

Hamilton Psychiatric Hospital
Community Housing Coordination Service
Social Work Department
Homes for Special Care Program
P.O. Box 585
Hamilton, Ontario
L8N 3K7
Submitted by Mr. Brian Leckie

Hamilton–Wentworth District Health Council
Box 2085 Main Post Office
Hamilton, Ontario
L8N 3R5
Submitted by Dr. Nick Kates &
Dr. Barrie Humphrey

Home Care Program for Metropolitan Toronto
45 Sheppard Avenue East
Willowdale, Ontario
M2N 5W9

Homeward Mental Health Projects of Metro Toronto
c/o 1001 Queen Street West
Toronto, Ontario
M6J 1H4
Submitted by Ms. Barbara Everett

Hong Fook Mental Health Association
41 Cecil Street
Toronto, Ontario
M5T 1N1
Submitted by Ms. Rose Lee &
Mr. Raymond Chung

Hotel Dieu of St. Joseph Hospital
1030 Ouellette Avenue
Windsor, Ontario
N9A 1E1
Submitted by Dr. N.A. Fretz

Huron–Perth Mental Health Implementation Committee
c/o Mr. Ken Englestad
Alexandra Marine & General Hospital
120 Napier Street
Goderich, Ontario
N7A 1W5
Submitted by Dr. Maarten Bokhout

Huron–Perth Mental Health Implementation Committee
c/o Mr. Ken Englestad
Alexandra Marine & General Hospital
120 Napier Street
Goderich, Ontario
N7A 1W5
Submitted by Ms. Mary Lynn Thompson
& Dr. Maarten Bokhout

International Association of Psychosocial Rehabilitation Services, Ontario Chapter
P.O. Box 433
Station C
1117 Queen Street West
Toronto, Ontario
M6J 1J0
Submitted by Ms. Jenny Carver

John Noble Home
97 Mt. Pleasant Street
Brantford, Ontario
N3T 1T5
Submitted by Ms. Janice Mills

Kenora Mental Health Planning and Advisory Committee
c/o Day Treatment Program
21 Wolseley Street West
Kenora, Ontario
T9N 3W7

Kenora–Rainy River District Health Council
101 Main Street South
Kenora, Ontario
P9N 1T1

Kent County District Health Council
75 Thames Street
Chatham, Ontario
N7L 1S4
Submitted by Mr. Peter Deane

Kingston, Frontenac & Lennox & Addington District Health Council
544 Princess Street
P.O. Box 1690
Kingston, Ontario
K7L 5J6

Kingston, Frontenac & Lennox & Addington District Health Council
Mental Health Care Committee
544 Princess Street
P.O. Box 1690
Kingston, Ontario
K7L 5J6

Lakehead District Roman Catholic Separate School Board
212 E. Miles Street
Thunder Bay, Ontario
P7C 4Y5

Lakehead Psychiatric Hospital
Box 2930
Thunder Bay, Ontario
P7A 1S9

The Lakehead Social Planning Council
221 Bay Street
Thunder Bay, Ontario
P7B 1R1

Lambton District Health Council
265 North Front Street
Sarnia, Ontario
N7T 7X1
Submitted by Mr. Paul H. Rennie

Manic-Depressive Association of
Metropolitan Toronto
40 Orchard View Blvd.
Toronto, Ontario
M4R 1B9
Submitted by Mr. Ed Demchuk

Manitoulin-Sudbury District Health Council
142 Durham Street South
Sudbury, Ontario
P3E 3M7
Submitted by Ms. Gale Murray

Margaret Frazer House
301 Broadview Avenue
Toronto, Ontario
M4M 2G8
Submitted by Ms. Heather Hesson

Mental Health Program Services of
Metropolitan Toronto
121 Kennedy Avenue
Toronto, Ontario
M6S 2X8
Submitted by Ms. Elizabeth Janzen

Metropolitan Toronto District Health Council
1246 Yonge Street
Toronto, Ontario
M4T 1W5
Submitted by Dr. J.R. Nethercott

Metropolitan Toronto District Health Council
1246 Yonge Street
Toronto, Ontario
M4T 1W5

Metropolitan District Health Council
Mental Health Services
Ad Hoc Group
1246 Yonge Street
Toronto, Ontario
M4T 1W5
Submitted by Mr. Grant Lowery

Metropolitan Toronto District Health Council
Mental Health Care Committee
Advisory Group on the Coordination of
Metropolitan Toronto
Mental Health Services
Task Force on Mental Health Epidemiology
1246 Yonge Street
Toronto, Ontario
M4T 1W5

Metropolitan Toronto Multicultural Mental
Health Group
c/o 120 Eglinton Avenue East
Toronto, Ontario
M4P 1E2
Submitted by Ms. Nancy Douglas

Metropolitan Toronto Multicultural Mental
Health Group
c/o 120 Eglinton Avenue East
Toronto, Ontario M4P 1E2
Submitted by Ms. Nancy Douglas &
Ms. Rose Lee

Mount Sinai Hospital
Department of Psychiatry
600 University Avenue
Toronto, Ontario
M5G 1X5
Submitted by Dr. Mary V. Seeman

Multicultural Health Coalition
Sante Multiculturelle
1017 Wilson Avenue
Downsview, Ontario
M3K 1Z1
Submitted by Dr. Ralph Masi

Multicultural Health Coalition
Sante Multiculturelle
Ottawa Division
16 Powell Avenue
Ottawa, Ontario
K1S 2A1
Submitted by Mr. Arthur Stinson

National Eating Disorder Information Centre
200 Elizabeth Street
College Wing, 2–332
Toronto, Ontario
M5G 2C4
Submitted by Ms. Joan Faulkner

Niagara District Health Council
Box 1059
1440 Peham Street South
Fonthill, Ontario
L0S 1E0
Submitted by Mr. Gary N. Zalot

North Bay Psychiatric Hospital
Community Advisory Board
P.O. Box 3010
North Bay, Ontario
P1B 8L1

North of Superior Community Mental Health Program
Box 911
Geraldton, Ontario
P0T 1M0

Northwestern Ontario Mental Health Network
c/o Atikokan General Hospital
120–130 Dorothy Street
Atikokan, Ontario
P0T 1C0

Ontario Association of Children's Mental Health Centres
40 St. Clair Avenue East
Toronto, Ontario
M4T 1M9
Submitted by Mr. W.M. Rothery

Ontario Association of Children's Mental Health Centres
40 St. Clair Avenue East
Toronto, Ontario
M4T 1M9
Submitted by Mr. Wilfred L. Innerd

Ontario Association of Children's Mental Health Centres
40 St. Clair Avenue East
Toronto, Ontario
M4T 1M9
Submitted by Ms. Sheila Weinstock &
Mr. W.M. Rothery

Ontario District Health Councils' Executive Directors
c/o Ministry of Health
10th Floor Hepburn Block
80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Ontario Friends of Schizophrenics
P.O. Box 217
Station "O"
Toronto, Ontario
M4A 2W3
Submitted by Ms. June Conway Beeby

Ontario Friends of Schizophrenics
Metropolitan Toronto Chapter
Family Support Centre
1300 Yonge Street
Toronto, Ontario
M4T 1X3
Submitted by Ms. Claire McLaughlin

Ontario Friends of Schizophrenics
Thunder Bay Chapter
240 Robinson Drive
Thunder Bay, Ontario
P7A 6G5
Submitted by Mr. Bob Schumacher

Ontario Medical Association Committee on
Medical Care and Practice
250 Bloor Street East
Toronto, Ontario
M4W 3P8
Submitted by Dr. B.J. Goldlist

Ontario Ministry of Community and Social
Services
Services for Disabled Persons Branch
700 Bay Street, 11th Floor
Toronto, Ontario
M5G 1Z6
Submitted by Ms. Sandra Lang

Ontario Ministry of Community
and Social Services
Windsor Area Office
250 Windsor Avenue
Windsor, Ontario
N9A 6V9
Submitted by Ms. S.L. Cunningham

Ottawa–Carleton Regional District Health
Council
1355 Bank Street
Ottawa, Ontario
K1H 8K7
Submitted by Dr. Alistair Catterson &
Ms. Mary Fowler

Ottawa–Carleton Regional District Health
Council
1355 Bank Street
Ottawa, Ontario
K1H 8K7

Ottawa–Carleton Regional District Health
Council
Hospital Psychiatric Services
Steering Committee
1355 Bank Street
Ottawa, Ontario
K1H 8K7

Ottawa–Carleton Regional District Health
Council
Joint Committee of the Chiefs of Psychiatry
and the Mental Health Board to Council
1355 Bank Street
Ottawa, Ontario
K1H 8K9

Ottawa–Carleton Regional District Health
Council
The Mental Health Board to Council
1355 Bank Street
Ottawa, Ontario
K1H 8K9

Ottawa–Carleton Regional District Health
Council
The Mental Health Operational Plan
Sub–Committee
1355 Bank Street
Ottawa, Ontario
K1H 8K9

Ottawa–Carleton Regional District Health
Council.
The Psychiatric Patient Survey Steering
Committee
1355 Bank Street
Ottawa, Ontario
K1H 8K9

Peel Career Assessment Services Inc.
5266 General Road Unit 3
Mississauga, Ontario
L4W 1Z7
Submitted by Mr. George Lytwyn

Peel Mental Health Housing Coalition
P.O. Box 406
Streetsville Postal Station
Mississauga, Ontario
L5M 2B9

Penetanguishene Mental Health Centre
Outpatient Services
P.O. Box 698
Penetanguishene, Ontario
L0K 1P0
Submitted by Ms. Jennifer Street

Persons United for Self Help in Ontario
597 Parliament Street
Toronto, Ontario
M4X 1W3
Submitted by Ms. Cathy McPherson

Peterborough Chapter of the Friends of Schizophrenics
c/o Canadian Mental Health Office
312 George Street West
Peterborough, Ontario
K9J 6Y5

Peterborough Civic Hospital
Schizophrenic Clinic
899 Weller Street
Peterborough, Ontario
K9J 7C6

Peterborough County City Health Unit
835 Weller Street
Peterborough, Ontario
K9J 4Y1
Submitted by Ms. Sandy White

Psychiatric Patient Advocate Office
56 Wellesley Street West
Toronto, Ontario
M5S 2S3
Submitted by Ms. Mary Beth Valentine

Public General Hospital
Mental Health Clinic
106 Emma Street
Chatham, Ontario
N7L 1A8
Submitted by Ms. H. Earl-McCubbin

Queen Street Mental Health Centre
1001 Queen Street West
Toronto, Ontario
M6J 1H4
Submitted by Ms. D. Macfarlane

Rainy River Valley Community Mental Health Services
110 Victoria Avenue
Fort Frances, Ontario
P9A 2B7
Submitted by Mr. Jon Thompson

Renfrew County and District Health Unit
65 Dunn Street
P.O. Box 730
Barry's Bay, Ontario
K0J 1B0
Submitted by Ms. Elizabeth Peplinskie

Rideau Valley District Health Council
Health Planning and Advisory Body for the Counties of Lanark, Leeds, and Grenville
1 Abel Street
Smith Falls, Ontario
K7A 4T4
Submitted by Ms. Stella Turner

Ross Memorial Hospital Community Mental Health Centre
282 Kent Street
West Lindsay, Ontario
K9V 2Z6
Submitted by Ms. Molly McCrea

Royal Ottawa Hospital
Royal Ottawa Health Care Group
1145 Carling Street
Ottawa, Ontario
K1Z 7K4
Submitted by Mr. George Langill

The Royal Victoria Hospital of Barrie.
Department of Psychiatric Services
76 Ross Street
Barrie, Ontario
L4N 1G4
Submitted by Mr. Chris Sullivan

Second Chance Employment Counselling
(Wellington) Inc.
177 Norfolk Street
Guelph, Ontario
N1H 4K1
Submitted by Ms. Sharon Severinski

Sioux Lookout Zone Hospital
Box 1500
Sioux Lookout, Ontario
P0V 2T0
Submitted by Ms. Joyce Timpson

St. Joseph's General Hospital
Box 3251
Thunder Bay, Ontario
P7B 5G7

St. Stephen's Community House
91 Bellevue Avenue
Toronto, Ontario
M5T 2N8
Submitted by Ms. Valerie March

St. Thomas Psychiatric Hospital
P.O. Box 2004
St. Thomas, Ontario
N5P 3V9
Submitted by Mr. Robert Cunningham

St. Thomas Psychiatric Hospital.
Windsor Liaison Office
P.O. Box 2004
St. Thomas, Ontario
N5P 3V9

Sunnybrook Community Psychiatric Services
for the Elderly
Sunnybrook Medical Centre Department of
Psychiatry
2075 Bayview Avenue
Toronto, Ontario
M5N 3M5

Thames Valley District Health Council
826 King Street
London, Ontario
N5W 2X6
Submitted by Dr. Mario Faveri

Thunder Bay and District Health Coalition
221 Bay Street
Thunder Bay, Ontario
P7V 1R1

Thunder Bay District Health Council
516 Victoria Avenue
Thunder Bay, Ontario
P7C 1A7

Thunder Bay Medical Society
c/o Dr. K.L. Arnold
Port Arthur Clinic
194 North Court Street
Thunder Bay, Ontario
P7B 4V7
Submitted by Dr. Ruth E. Kajander

Thunder Bay Multicultural Association
P.O. Box 2334
Thunder Bay, Ontario
P7B 5E9
Submitted by Mr. John Potestio

Thunder Bay Psychiatric Association
c/o 202 Hodder Avenue
Thunder Bay, Ontario
P7A 1S9
Submitted by Dr. Ruth E. Kajander

Timiskaming Health Unit
New Liskeard Office
221 Whitewood Avenue
P.O. Box 1240
New Liskeard, Ontario
P0J 1P0
Submitted by Dr. Brian Primrose &
Ms. Elizabeth Cawley

Toronto East General and Orthopaedic Hospital Inc.
825 Coxwell Avenue
Toronto, Ontario
M4C 3E7
Submitted by Dr. L. Kiraly

Union Place
261, 8th Street East
Owen Sound, Ontario
N4K 1L2
Submitted by Mr. Thomas Jenks

University of Toronto
Department of Psychiatry
Division of Child Psychiatry
555 University Avenue
Toronto, Ontario
M5G 1X8
Submitted by Dr. Paul D. Steinhauer

Victorian Order of Nurses
Windsor–Essex County Branch
410 Giles Boulevard East
Windsor, Ontario
N9A 4C6
Submitted by Ms. Patricia Brunelle &
Ms. Shirley Quick

Vocational Rehabilitation Task Force of Metropolitan Toronto
120 Eglinton Avenue East
Toronto, Ontario
M4P 1E2
Submitted by Mr. Peter Whiteley &
Mr. Bob Sargalis

Waterloo Region District Health Council
75 King Street South
Waterloo Town Square
Waterloo, Ontario
N2J 1P2

Waterloo Region Supportive Housing Coalition
c/o University of Waterloo
Faculty of Environmental Studies
School of Urban & Regional Planning
Waterloo, Ontario
N2L 3G1
Submitted by Mr. Geoff Nelson &
Mr. Brent Hall &
Ms. Amanda Kroger &
Mr. Ken Parsons

Waterloo Region Supportive Housing Coalition
c/o Canadian Mental Health Association
Waterloo Branch
607 King Street, Suite 202
Kitchener, Ontario
N2G 1C7
Submitted by Mr. Geoff Nelson &
Mr. Brent Hall &
Mr. Ken Parsons &
Mr. Bill McKay &
Ms. Wendy Czarny &
Ms. Marj Mank

Wellington–Dufferin District Health Council
317 Speedvale Avenue East
Guelph, Ontario
N1E 1N3
Submitted by Mr. Rob Simpson

Whitby Psychiatric Hospital
Community Advisory Board
Box 613
Whitby, Ontario
L1N 5S9
Submitted by Mr. H.S. Polak

Whitby Psychiatric Hospital
Patient Government
Box 613
Whitby, Ontario
L1N 5S9

Windsor–Essex County Health Unit
1005 Ouellette Avenue
Windsor, Ontario
N9A 4J8
Submitted by Ms. Dorothy Travis &
Ms. Elizabeth Haugh

York Community Services'
Psychiatric Aftercare Program
1651 Keele Street
Toronto, Ontario
M6M 3W2
Submitted by Ms. Barbara Titherington

APPENDIX III

PROVINCIAL COMMUNITY MENTAL HEALTH COMMITTEE PRESENTATIONS AND CONSULTATIONS DECEMBER 4, 1987 – JANUARY 29, 1988

ACFO
Mr. Alcide Gour

ADDICTION RESEARCH FOUNDATION
Dr. Mario Faveri

ALGOMA COMMUNITY PSYCHIATRIC CASE MANAGEMENT PROGRAM
Ms. Trudy Donovan

ALGOMA DISTRICT HEALTH COUNCIL
Ms. Margaret Dobie
Mr. Anthony Ubaldi

ALPHA COURT
Ms. Fleurette LeClair

ANGLICAN HOUSES
Mr. Terry McCullum

ATIKOKAN GENERAL HOSPITAL. ADULT MENTAL HEALTH PROGRAM
Mr. Richard Harrington

BOUNDLESS ADVENTURES
Mr. Steve Gottlieb

BRANT DISTRICT HEALTH COUNCIL
Mr. Michael Park

BROCKVILLE PSYCHIATRIC HOSPITAL
Dr. Ron Draper

CAMBRIDGE ACTIVE SELF-HELP
Mr. Bill McKay

CANADIAN HEARING SOCIETY
Ms. Cathy Cuthbertson

CANADIAN MENTAL HEALTH ASSOCIATION BARRIE/SIMCOE BRANCH
Mr. Gerald Gignac

CANADIAN MENTAL HEALTH ASSOCIATION BRANT COUNTY BRANCH
Ms. Marguerite Ceschi-Smith

CANADIAN MENTAL HEALTH ASSOCIATION CORNWALL BRANCH
Mr. Gordon Baldwin

CANADIAN MENTAL HEALTH ASSOCIATION DURHAM BRANCH
Mr. Henry Silver

CANADIAN MENTAL HEALTH ASSOCIATION KENT COUNTY BRANCH
Ms. Barbara Garvin

CANADIAN MENTAL HEALTH ASSOCIATION LAMBTON BRANCH
Ms. Marilynne Ryan

CANADIAN MENTAL HEALTH ASSOCIATION METROPOLITAN TORONTO BRANCH

Mr. Steve Lurie

CANADIAN MENTAL HEALTH ASSOCIATION PEEL BRANCH

Ms. Sandy Milakovic Mr. Ted Overdijk

CANADIAN MENTAL HEALTH ASSOCIATION THUNDER BAY BRANCH

Ms. Bev Cadene
Ms. Pauline Lavallee

CANADIAN MENTAL HEALTH ASSOCIATION TIMMINS BRANCH

Ms. Judy Shanks

CANADIAN MENTAL HEALTH ASSOCIATION VICTORIA COUNTY STEERING COMMITTEE

Ms. Jackie McAllister

CANADIAN MENTAL HEALTH ASSOCIATION WINDSOR–ESSEX COUNTY BRANCH

Ms. Pamela Hines

CENTRAL TORONTO YOUTH SERVICES

Ms. Jennifer Pyke

CENTRAL TORONTO YOUTH SERVICES NEW OUTLOOK

Mr. Grant Lowery

COCHRANE DISTRICT HEALTH COUNCIL

Mr. Jack Atkinson
Ms. Anne Vincent

COCHRANE DISTRICT HEALTH COUNCIL MENTAL HEALTH SERVICES ADVISORY COMMITTEE

Ms. Rachelle Demers

COMMUNITY AND SOCIAL SERVICES FOR THE COUNTY OF KENT

Ms. M.E. Kuchta

COMMUNITY OCCUPATIONAL THERAPISTS ASSOCIATION PSYCHOGERIATRIC SERVICES

Ms. Diana Anderson

COMMUNITY RESOURCES CONSULTANTS OF TORONTO

Mr. Ron Ballantyne
Mr. Dale Butteril
Ms. Marg Heinz
Mr. Bob Sargalis

COORDINATING & ADVISORY COUNCIL FOR MENTAL HEALTH SERVICES IN YORK REGION

Dr. Robert Camargo
Ms. Charlotte Cameron
Ms. Donna Noble
Ms. Nana Rosenburger
Mr. James Simon

CORNWALL GENERAL HOSPITAL MENTAL HEALTH DIVISION

Ms. Janet Simms–Baldwin

CORNWALL, ONTARIO

Dr. Claude Manigat

COUNTY OF SIMCOE DISTRICT HEALTH COUNCIL

Mr. William Goodwin

COUNTY OF SIMCOE DISTRICT HEALTH COUNCIL MENTAL HEALTH COMMITTEE

Mr. Claude Buck

DISTRICT HEALTH COUNCIL OF EASTERN ONTARIO

Mr. Guy Leger
Mr. Murray Richer
Mr. Donald St–Pierre

DURHAM REGION DISTRICT HEALTH COUNCIL

Mr. Ron Shaw

EASTERN ONTARIO HEALTH UNIT

Ms. Constance Drouin
Mrs. Reina Smith

ESSEX COUNTY DISTRICT HEALTH COUNCIL

Ms. Mardee Driscoll
Ms. Caroline Taylor
Mr. Coty Thompson

ESSEX COUNTY DISTRICT HEALTH COUNCIL MENTAL HEALTH COMMITTEE

Ms. Mary Jean Gallagher

ETOBICOKE MENTAL HEALTH SERVICES AGENCY

Ms. Marlene Swarbrick

FAMILY FOCUS LEEDS & GRENVILLE

Ms. Janice Giffen

FORT FRANCES CLINIC

Dr. R. Moulton

FRIENDS AND ADVOCATES CENTRE NORTH YORK

Ms. Asta Dvorak

FRIENDS OF SCHIZOPHRENICS BRAMPTON CHAPTER

Ms. Diana Fishleigh
Mr. Ben Hogendam

GREY–BRUCE DISTRICT HEALTH COUNCIL

Mr. Thomas Jenks
Ms. Karen Levenick

GREY BRUCE DISTRICT HEALTH COUNCIL MENTAL HEALTH ADVISORY COMMITTEE

Mr. Morley Hammond

GREY BRUCE REGIONAL HEALTH CENTRE

Mr. Timothy L. Hill

GREY BRUCE REGIONAL HEALTH CENTRE MENTAL HEALTH AFTERCARE PROGRAM

Mr. Michael Schwan

HALDIMAND NORFOLK DISTRICT HEALTH COUNCIL

Mr. Anthony J. Bailey

HALIBURTON, KAWARTHA AND PINE RIDGE DISTRICT HEALTH COUNCIL

Mr. Alan Worthington

HAMILTON WENTWORTH DISTRICT HEALTH COUNCIL

Dr. Barrie Humphrey
Dr. Nick Kates

HOME CARE PROGRAM FOR METROPOLITAN TORONTO

Ms. Marie Lund

HONG FOOK MENTAL HEALTH ASSOCIATION

Ms. Rose Lee

HURON-PERTH MENTAL HEALTH IMPLEMENTATION COMMITTEE

Dr. Maarten Bokhout
Ms. Mary Lynn Thompson

JAMES BAY GENERAL HOSPITAL

Ms. Louise Maheu

KENORA RAINY RIVER DISTRICT HEALTH COUNCIL

Mr. Bill Reynolds

KENT COUNTY DISTRICT HEALTH COUNCIL

Mr. Peter Deane
Mr. Jack Lambe

KINGSTON, FRONTENAC & LENNOX & ADDINGTON DISTRICT HEALTH COUNCIL

Mr. J. Mackenzie

KINGSTON PSYCHIATRIC HOSPITAL

Ms. Lorna Jean Edmonds

LAKEHEAD DISTRICT ROMAN CATHOLIC SEPARATE SCHOOLBOARD

Mr. John Stevens

LAKEHEAD PSYCHIATRIC HOSPITAL

Dr. R. Frost
Mr. Foster Loucks

LAKEHEAD SOCIAL PLANNING COUNCIL

Ms. Nancy Clarke
Ms. Brenda Reimer

LAMBTON DISTRICT HEALTH COUNCIL

Mr. Paul H. Rennie

LAMBTON DISTRICT HEALTH COUNCIL MENTAL HEALTH COMMITTEE

Ms. Ila Campbell

MADISON AVENUE RESIDENCES INC.

Mr. Chris Higgins

MANIC DEPRESSIVE ASSOCIATION OF METROPOLITAN TORONTO

Ms. Joyce Santamora

MANITOULIN-SUDBURY DISTRICT HEALTH COUNCIL

Ms. Joanna Wells

MARY MCGILL COMMUNITY MENTAL HEALTH CENTRE

Ms. Mary Lou Moyer

MENTAL HEALTH PROGRAM SERVICES OF METROPOLITAN TORONTO

Ms. Elizabeth Janzen

METRO WINDSOR-ESSEX COUNTY HEALTH UNIT

Ms. D. Travis

METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL

Ms. Evelyn Kent

METROPOLITAN TORONTO MULTICULTURAL MENTAL HEALTH GROUP

Ms. Nancy Douglas

MINTO COUNSELLING CENTRE

Ms. Wilma Binnema

MISSISSAUGA HOSPITAL. MENTAL HEALTH CLINIC

Mr. Bruce Whitney

NIAGARA DISTRICT HEALTH COUNCIL

Mr. Gary N. Zalot

NORTH BAY PSYCHIATRIC HOSPITAL COMMUNITY ADVISORY BOARD

Ms. Maureen Lecroix

NORTH OF SUPERIOR COMMUNITY MENTAL HEALTH PROGRAM

Mr. Tim Ellard

NORTH YORK INTER-AGENCY COUNCIL MENTAL HEALTH SUBCOMMITTEE

Mr. Michael Aiken

ONTARIO FRIENDS OF SCHIZOPHRENICS METROPOLITAN TORONTO CHAPTER

Ms. Claire McLaughlin

ONTARIO FRIENDS OF SCHIZOPHRENICS THUNDER BAY CHAPTER

Mr. Bob Schumacher

ONTARIO MEDICAL ASSOCIATION

Dr. B.F. Hoffman

OSHAWA GENERAL HOSPITAL

Mr. William Lewis

OTTAWA-CARLETON REGIONAL DISTRICT HEALTH COUNCIL

Dr. Alistair Catterson

Ms. Mary Fowler

PARRY SOUND DISTRICT GENERAL HOSPITAL

Mr. Norman MacIver

PEEL DISTRICT HEALTH COUNCIL MENTAL HEALTH AND DEPENDENCY COMMITTEE

Ms. Delores Apps

PEEL MENTAL HEALTH HOUSING COALITION

Ms. Louise Brown

PENETANGUISHENE MENTAL HEALTH CENTRE

Ms. Jennifer Street

PETERBOROUGH CIVIC HOSPITAL SCHIZOPHRENIA CLINIC

Ms. Joanne Bazak

PETERBOROUGH COUNTY CITY HEALTH UNIT

Ms. Sandy White

PHASED HOUSING CORPORATION

Ms. Isabel Morton

PRESCOTT-RUSSELL ROYAL COMTOIS CENTRE

Dr. Neena Campbell-Soper
Mr. Jim Ness
Mr. Marc Ranger

PROGRESS PLACE

Ms. Brenda Singer

PSYCHIATRIC PATIENT ADVOCATE OFFICE

Ms. S. Atkinson Ms. Mary Beth Valentine

PUBLIC GENERAL HOSPITAL MENTAL HEALTH CLINIC -CHATHAM

Dr. G.R. Getty

RAINY RIVER VALLEY COMMUNITY MENTAL HEALTH SERVICES

Mr. Jon Thompson

RIDEAU VALLEY DISTRICT HEALTH COUNCIL

Ms. Ann Kilpatrick
Ms. Wanda MacDonald
Mr. Robert Walker

RIDEAU VALLEY DISTRICT HEALTH COUNCIL MENTAL HEALTH BOARD

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Ms. Marg Shaw

WHITBY REDEVELOPMENT COMMUNITY PROGRAM WORK GROUP
Dr. Donald Wasylenki

YORK COMMUNITY SERVICES PSYCHIATRIC AFTERCARE PROGRAM
Ms. Barb Titherington

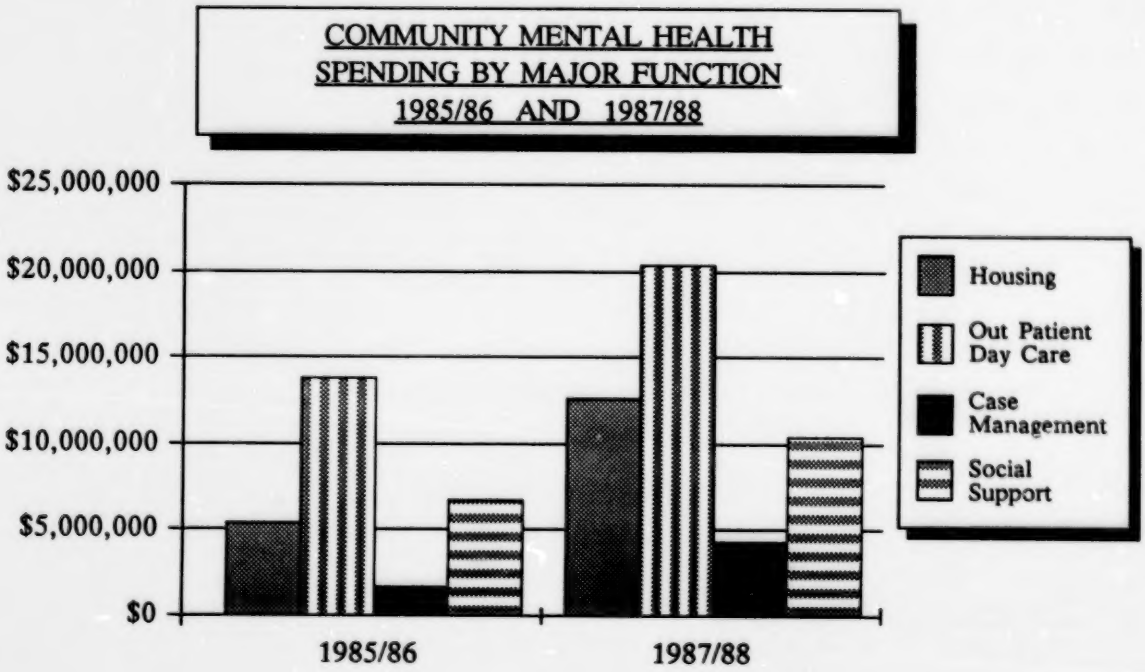
APPENDIX IV

ESTIMATES* OF THE PREVALENCE^ OF COMMON PSYCHIATRIC DISORDERS

	LOW	HIGH
Major depression without bereavement	175,000	450,000
Panic or obsessive compulsive disorders	150,000	400,000
Phobias	432,000	1,400,000
Substance abuse/dependency	534,000	819,000

* Application of Myers et al (1984) figures of prevalence of psychiatric disorders in the community, applied to Ontario's population base of 9.2 million. When assuming a total of 1.5 million people in Ontario having some symptom of mental illness it should be noted that some persons may be suffering from more than one type of psychiatric disorder.

^ Prevalence refers to the number of cases presently existing and active in a given population at any particular time.


COMMUNITY MENTAL HEALTH
SPENDING BY MAJOR FUNCTION
1985/86 AND 1987/88
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
1985/86
1987/88
Housing
Out Patient Day Care
Case Management
Social Support

COMMUNITY MENTAL HEALTH SPENDING 1985/86 and 1987/88

PROGRAM TYPE	1985/86	1987/88	CHANGE	% CHANGE from 1985/86
Prevention				
Other	$493,873	$820,212	$326,339	66.08%
Hospital				
Total	$493,873	$820,212	$326,339	66.08%
% of Total Spending	1.19%	1.20%	0.01%	0.43%
Self-Help				
Other	$107,710	$104,982	($2,728)	-2.53%
Hospital				
Total	$107,710	$104,982	($2,728)	-2.53%
% of Total Spending	0.26%	0.15%	-0.11%	-41.06%
Crisis				
Other	$240,370		($240,370)	-100.00%
Hospital	$982,328	$1,962,717	$980,389	99.80%
Total	$1,222,698	$1,962,717	$740,019	60.52%
% of Total Spending	2.95%	2.87%	-.09%	-2.93%
Case Management				
Other	$1,415,621	$4,158,494	$2,742,873	193.76%
Hospital	$246,973	$153,060	($93,913)	-38.03%
Total	$1,662,594	$4,311,554	$2,648,960	159.33%
% of Total Spending	4.02%	6.30%	2.28%	56.83%
Housing				
Other	$4,882,443	$11,427,480	$6,545,037	134.05%
Hospital	$476,068	$1,166,431	$690,363	145.01%
Total	$5,358,511	$12,593,911	$7,235,400	135.03%
% of Total Spending	12.95%	18.41%	5.46%	42.13%
Vocational				
Other	$1,232,222	$2,694,964	$1,462,742	118.71%
Hospital	$270,568	$163,151	($107,417)	-39.70%
Total	$1,502,790	$2,858,115	$1,355,325	90.19%
% of Total Spending	3.63%	4.18%	0.55%	15.01%
Psychogeriatric				
Other	$583,147	$254,483	($328,664)	-56.36%
Hospital	$1,509,702	$3,204,893	$1,695,191	112.29%
Total	$2,092,849	$3,459,376	$1,366,527	65.30%
% of Total Spending	5.06%	5.06%	0.00%	-0.04%
Sessionals				
Other				
Hospital	$6,586,030	$7,943,741	$1,357,711	20.62%
Total	$6,586,030	$7,943,741	$1,357,711	20.62%
% of Total Spending	15.92%	11.61%	-4.31%	-27.06%
Co-Ordination				
Other	$1,738,097	$3,633,013	$1,894,916	109.02%
Hospital	$172,156	$73,751	($98,405)	-57.16%
Total	$1,910,253	$3,706,764	$1,796,511	94.05%
% of Total Spending	4.62%	5.42%	0.80%	17.35%

COMMUNITY MENTAL HEALTH SPENDING 1985/86 and 1987/88

PROGRAM TYPE	1985/86	1987/88	CHANGE	% CHANGE from 1985/86
Multicomp				
Other		$2,414,870		
Hospital		$479,983		
Total		$2,894,853		
% of Total Spending		4.23%		
Rehabilitation				
Other		$7,054,515		
Hospital		$133,504		
Total		$7,188,019		
% of Total Spending		10.50%		
Volunteer				
Other		$242,515		
Hospital		$37,972		
Total		$280,487		
% of Total Spending		0.41%		
Psychosocial				
Other	$6,357,729	$9,711,900	$3,354,171	52.76%
Hospital	$341,796	$651,459	$309,663	90.60%
Total	$6,699,525	$10,363,359	$3,663,834	54.69%
% of Total Spending	16.19%	15.15%	-1.04%	-6.45%
Clinics				
Other	$819,511	$7,928,732		
Hospital	$310,666	$7,846,372		
Total	$1,130,177	$15,775,104		
% of Total Spending		23.05%		
Daycare				
Other		$206,103		
Hospital		$4,318,816		
Total		$4,524,919		
% of Total Spending		6.61%		
Out Patient Day Care				
Other	$4,203,471	$8,134,835	$3,931,364	93.53%
Hospital	$9,538,873	$12,165,188	$2,626,315	27.53%
Total	$13,742,344	$20,300,023	$6,557,679	47.72%
% of Total Spending	33.21%	29.67%	-3.54%	-10.67%
Total CMH	$41,379,177	$68,424,754	$27,045,577	65.36%
Other CMH	$21,254,683	$40,940,363	$19,685,680	92.62%
%ge Total	51.37%	59.83%	72.79%	8.47%
Hospital CMH	$20,124,494	$27,484,391	$7,359,897	36.57%
%GE Total	48.63%	40.17%	27.21%	-8.47%

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Cover: The three stylized hands in the puzzle represent the three levels of involvement: individual, community and institution. The human hand represents the tangible effort required to put the pieces together.

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